

4988

CERTIFICATE OF DEATH

04977

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> | | | | c. LENGTH OF STAY IN 1b <u>27 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Bernard</u> Middle <u>William</u> Last <u>Adams</u> | | | | 4. DATE OF DEATH Month <u>5</u> Day <u>29</u> Year <u>1959</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Oct. 15, 1900</u> | |
| 9. AGE (In years lost birthday) <u>58</u> yrs. | | IF UNDER 1 YEAR Months <u>5</u> Days <u>29</u> Hours <u>19</u> Min. | | IF UNDER 24 HRS. Months <u>5</u> Days <u>29</u> Hours <u>19</u> Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pressman</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Celanese Corp.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Cumberland, Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>William Adams</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Jackson</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>214-07-4705</u> | | | |
| 17. INFORMANT <u>Mrs. Martha Brant</u> | | | | Address <u>64 N. Mechanic St., Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure & Cachexia</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Bronchogenic Carcinoma, left lung, with metastases</u> DUE TO (c) <u>6 months</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>few weeks</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>May 2nd</u> , 19 <u>59</u> , to <u>May 29th</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 29th</u> , 19 <u>59</u> , and that death occurred at <u>1:50 PM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Wyand F. Doerner, Jr.</u> | | | | ADDRESS (Street, city or town, state) <u>Algonquin Hotel, Cumberland, Md.</u> | | | |
| DATE SIGNED <u>6/1/59</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>Wyand F. Doerner, Jr., M.D.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6/1/59</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u> | | 22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George</u> | | | | ADDRESS <u>Cumberland, Md.</u> | | 24a. REC'D BY REGISTRAR <u>JUN 3 '59</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

1999

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

UNDERLYING

PERIOD OF ILLNESS

DATE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

UNDERLYING

PERIOD OF ILLNESS

DATE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

UNDERLYING

PERIOD OF ILLNESS

DATE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

UNDERLYING

PERIOD OF ILLNESS

DATE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

UNDERLYING

PERIOD OF ILLNESS

DATE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

UNDERLYING

PERIOD OF ILLNESS

DATE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

UNDERLYING

PERIOD OF ILLNESS

DATE OF BIRTH

- MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5067 CERTIFICATE OF DEATH

Reg. Dist. No. **04978**

| | | | | | | | |
|--|----------------------------------|--|--|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland | | c. LENGTH OF STAY IN 1b 51 yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS 1 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First HAZEL Middle ALEXANDER Last ALEXANDER | | | 4. DATE OF DEATH Month 5 Day 4 Year 1959 | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 2/15/1908 | | 9. AGE (In years last birthday) 51 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk-- Dept. Store | | | 10b. KIND OF BUSINESS OR INDUSTRY Midland MD. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME George Clise | | | 14. MOTHER'S MAIDEN NAME Virginia Ross | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Mr. Don Alexander, Washington, MD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH sudden 2 mo | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 15, 1959 to May 4, 1959 , that I last saw the deceased alive on May 1, 1959 , and that death occurred at 12:15 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE W.O. McLane | | M.D. W.O. McLane MD | | ADDRESS (Street, city or town, state) Frostburg MD | | DATE SIGNED 5-5-59 | |
| PHYSICIAN'S NAME (Type) W.O. McLane MD | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/7/1959 | | 22c. NAME OF CEMETERY OR CREMATORY Memorial Park | | 22d. LOCATION (City, town, or county) (State) Frostburg, MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN | | | | ADDRESS LONACONING, MD. | | 24a. REC'D BY REGISTRAR DATE MAY 6 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2000 CERTIFICATE OF DEATH

| | | | | | |
|---------------------------------------|--|---------------------------------------|--|---|--|
| 1. NAME OF DECEASED JAMES EARL RAY | | 2. SEX Male | | 3. AGE 35 | |
| 4. DATE OF DEATH April 4, 1968 | | 5. TIME OF DEATH 2:01 PM | | 6. PLACE OF DEATH MEMPHIS, TENNESSEE | |
| 7. CAUSE OF DEATH SHOOTING | | 8. MANNER OF DEATH HOMICIDE | | 9. PLACE OF BIRTH MOBILE, ALABAMA | |
| 10. DATE OF BIRTH January 19, 1933 | | 11. PLACE OF BIRTH MOBILE, ALABAMA | | 12. OCCUPATION None | |
| 13. MARITAL STATUS Single | | 14. EDUCATION High School | | 15. RELIGION None | |
| 16. SIGNATURE OF DECEASED (None) | | 17. SIGNATURE OF NEXT OF KIN None | | 18. SIGNATURE OF PHYSICIAN None | |
| 19. SIGNATURE OF CORONER None | | 20. SIGNATURE OF JURY None | | 21. SIGNATURE OF JUDGE None | |
| 22. SIGNATURE OF COUNTY CLERK None | | 23. SIGNATURE OF STATE CLERK None | | 24. SIGNATURE OF VICE CLERK None | |

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THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE DISTRICT OF COLUMBIA, IN THE CITY OF WASHINGTON, D.C., IN THE YEAR 1968.

04370

20521

RECEIVED

Allegany

Maryland

Allegany

Providence, R.I.

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Providence, R.I.

Providence, R.I.

2

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U.S.A.

Maryland

Providence, R.I.

Providence, R.I.

Maryland

Providence, R.I.

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Providence, R.I.

Providence, R.I.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5052 CERTIFICATE OF DEATH

04980

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg | | c. LENGTH OF STAY IN 1b Lifetime | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital | | d. STREET ADDRESS 153 Washington Street | |
| 3. NAME OF DECEASED (Type or print) William Tildon Allen, Jr. | | 4. DATE OF DEATH Month May Day 8 Year 19 59. | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 1st, 1901 |
| 9. AGE (In years last birthday) 58 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | 11. IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Motorman | | 10b. KIND OF BUSINESS OR INDUSTRY Consolidation | |
| 11. BIRTHPLACE (State or foreign country) Eckhart | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13. FATHER'S NAME William Tildon Allen, Sr. | | 14. MOTHER'S MAIDEN NAME Elizabeth Klosterman | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214-01-6706 | |
| 17. INFORMANT Mrs. Anna Allen, 153 Washington St. Frostburg, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac - asthma 434.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH 3 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 11-2 , 19 58 , to 5-8 , 19 59 , that I last saw the deceased alive on 5-7 , 19 59 , and that death occurred at 1 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE H.C. Diehl | | ADDRESS (Street, city or town, state) 39 W. Main St., Frostburg, Md. | |
| PHYSICIAN'S NAME (Type) H.C. Diehl M.D., Frostburg, Md. | | DATE SIGNED 5/8/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5-11-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery | | 22d. LOCATION (City, town, or county) (State) Frostburg Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Paul H. Montesant | | 24a. REC'D BY REGISTRAR MAY 13 '59 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | | | |

5068

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midlothian | | c. LENGTH OF STAY IN 1b 40 Yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First William Middle H. Last Atkinson | | 4. DATE OF DEATH Month May Day 3rd Year 1959 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 14th, 1885 |
| 9. AGE (In years lost birthday) 74 yrs. | | 10. IF UNDER 1 YEAR: Months 74 Days 74 Hours 74 Min. 74 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp. | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Wintergreen Atkinson | | 14. MOTHER'S MAIDEN NAME Eliza Ellen Williams | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 216-10-4564 | |
| 17. INFORMANT Mrs. Viola Atkinson, Midlothian, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency DUE TO Bronchial Asthma Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) 4 mo (c) years | | INTERVAL BETWEEN ONSET AND DEATH 4 mo | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 1 , 19 59 , to May 3 , 19 59 , that I last saw the deceased alive on Apr 22 , 19 59 , and that death occurred at 10:11 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE W O McLane | | DATE SIGNED May 3 1959 | |
| PHYSICIAN'S NAME (Type) W. O. McLane, | | M.D. 167 E. Main Street, Frostburg Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 5-6-59 | 22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park | 22d. LOCATION (City, town, or county) (State) Frostburg, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, | | ADDRESS Frostburg, Md. | |
| 24a. REC'D BY REGISTRAR MAY 7 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Hume | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

0-1551

OFFICE OF THE ATTORNEY GENERAL

1908

Allegation

Allegation

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Allegation

No.

No.

No.

No.

No.

Joseph A. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4989 Item 8, Film G242,5-14-59, mmd
CERTIFICATE OF DEATH

04982

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|--|---|---|---|---|--------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> | | | | c. LENGTH OF STAY IN 1b <u>1 Mo 11 days</u> <u>X</u> <u>Frostburg</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u> | | | | d. STREET ADDRESS <u>Rt. #1, Box 150</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Milton</u> Last <u>Baker</u> | | 4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1959</u> | | | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3/3/98</u> <u>3/5/96</u> | | 9. AGE (In years lost birthday) <u>63</u> yrs. | IF UNDER 1 YEAR Months Days Hours | IF UNDER 24 HRS. Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Celanese</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Charles Baker</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Agnes Kirk</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. <u>217-10-5763</u> | | INFORMANT <u>Pt8s Chart</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma, rectum with metastases</u> 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 Year</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Feb. 4, 1958</u> to <u>May 1, 1959</u> , that I last saw the deceased alive on <u>April 30, 1959</u> , and that death occurred at <u>12:50</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE <u>R. W. Ballin</u> by <u>Dr. Jacobson</u> M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>S. M. Jacobson, M.D., 50 Pershing Street, Cumberland, Maryland</u> <u>R. W. Ballin, M.D., 62 Green Street, Cumberland, Maryland</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5/3/1959</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u> | | 22d. LOCATION (City, town, or county) (State) <u>Frostburg, MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>GEORGE EICHORN</u> | | | | ADDRESS <u>LONACONINE, MD.</u> | | 24a. REC'D BY REGISTRAR DATE <u>MAY 4 '59</u> | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kline</u> | |

01082

1982 - 1983

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1982-1983

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4990 CERTIFICATE OF DEATH

Reg. Dist. No. **04983**

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|--|--|---|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> | | | c. LENGTH OF STAY IN 1b <u>40 yrs.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>220 Potomac St.</u> | | | | d. STREET ADDRESS <u>305 Maryland Ave.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>L.</u> Last <u>Baker</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>23</u> Year <u>1959</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Jan. 26, 1890</u> | |
| 9. AGE (In years last birthday) <u>69</u> yrs. | | IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ | | IF UNDER 24 HRS. Hours _____ Min. _____ | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>Charles Houser</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT <u>Mrs. Regina Lambert, Cumberland, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO <u>Hypertensive Arteriosclerosis Under Venous Pressure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u> <u>years</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19____ | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from <u>Feb 12, 1956</u> to <u>April 4, 1959</u> , that I last saw the deceased alive on <u>April 4, 1959</u> , and that death occurred at <u>11:30 P.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>[Signature]</u> M.D. _____ | | | | ADDRESS (Street, city or town, state) <u>133 Virginia Ave. Cumberland, Md.</u> DATE SIGNED <u>5/25/59</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Dr. G. Overton Himmelwright</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5-26-1959</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Sunset Burial Park</u> | | 22d. LOCATION (City, town, or county) _____ (State) _____ | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>MAY 27 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH
BALTIMORE

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| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | | Usual Residence | | Cause of Death | | Date of Death | | Time of Death | | Place of Death | | Signature of Physician | | Signature of Registrar | |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4991

CERTIFICATE OF DEATH

04984

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | c. LENGTH OF STAY IN 1b 4/22/59 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Sara Ellen Barney | | 4. DATE OF DEATH Month Day Year May 12 19 59 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/9/1865 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Penn. | |
| 11. BIRTHPLACE (State or foreign country) Penn. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 13. FATHER'S NAME John Beatty | | 14. MOTHER'S MAIDEN NAME Ann Mann | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT P.O.Box 599 Cumberland, Md. | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypostasis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocardial Degeneration (c) Cerebral Arteriosclerosis | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Deterioration | | INTERVAL BETWEEN ONSET AND DEATH 12 hrs. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 4/22/59 , 19____, to 5/12/59 , 19____, that I last saw the deceased alive on 5/12/59 , 19____, and that death occurred at 8:40p M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 49 Greene St. 5/13/59 | | | |
| ACTUAL SIGNATURE James E. McLean | | M.D. 49 Greene St. | |
| PHYSICIAN'S NAME (Type) Dr. James E. McLean | | Cumberland, Maryland. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5-15-1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY Buck Valley Cem. | | 22d. LOCATION (City, town, or county) (State) Buck Valley, Penna. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George | | ADDRESS Cumberland, Md. | |
| 24a. REC'D BY REGISTRAR DATE MAY 18 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Frank | |

CERTIFICATE OF DEATH

1932

1932

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| <p>1. Name of Deceased: <u>Alfreda Louise Williams</u></p> | | <p>2. Sex: <u>Female</u></p> | |
| <p>3. Age: <u>10/9/1885</u></p> | | <p>4. Race: <u>White</u></p> | |
| <p>5. Birthplace: <u>U.S.A.</u></p> | | <p>6. Residence: <u>U.S.A.</u></p> | |
| <p>7. Date of Death: <u>10/9/1932</u></p> | | <p>8. Place of Death: <u>Home</u></p> | |
| <p>9. Cause of Death: <u>Records Maryland County Registrar</u></p> | | <p>10. Signature of Registrar: <u>U.S.A.</u></p> | |
| <p>11. Signature of Physician: <u>U.S.A.</u></p> | | <p>12. Signature of Coroner: <u>U.S.A.</u></p> | |
| <p>13. Signature of Burial Officer: <u>U.S.A.</u></p> | | <p>14. Signature of Witness: <u>U.S.A.</u></p> | |
| <p>15. Signature of Minister: <u>U.S.A.</u></p> | | <p>16. Signature of Undertaker: <u>U.S.A.</u></p> | |
| <p>17. Signature of Mortician: <u>U.S.A.</u></p> | | <p>18. Signature of Embalmer: <u>U.S.A.</u></p> | |
| <p>19. Signature of Funeral Home: <u>U.S.A.</u></p> | | <p>20. Signature of Cemetery: <u>U.S.A.</u></p> | |
| <p>21. Signature of Burial: <u>U.S.A.</u></p> | | <p>22. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>23. Signature of Burial: <u>U.S.A.</u></p> | | <p>24. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>25. Signature of Burial: <u>U.S.A.</u></p> | | <p>26. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>27. Signature of Burial: <u>U.S.A.</u></p> | | <p>28. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>29. Signature of Burial: <u>U.S.A.</u></p> | | <p>30. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>31. Signature of Burial: <u>U.S.A.</u></p> | | <p>32. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>33. Signature of Burial: <u>U.S.A.</u></p> | | <p>34. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>35. Signature of Burial: <u>U.S.A.</u></p> | | <p>36. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>37. Signature of Burial: <u>U.S.A.</u></p> | | <p>38. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>39. Signature of Burial: <u>U.S.A.</u></p> | | <p>40. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>41. Signature of Burial: <u>U.S.A.</u></p> | | <p>42. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>43. Signature of Burial: <u>U.S.A.</u></p> | | <p>44. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>45. Signature of Burial: <u>U.S.A.</u></p> | | <p>46. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>47. Signature of Burial: <u>U.S.A.</u></p> | | <p>48. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>49. Signature of Burial: <u>U.S.A.</u></p> | | <p>50. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>51. Signature of Burial: <u>U.S.A.</u></p> | | <p>52. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>53. Signature of Burial: <u>U.S.A.</u></p> | | <p>54. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>55. Signature of Burial: <u>U.S.A.</u></p> | | <p>56. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>57. Signature of Burial: <u>U.S.A.</u></p> | | <p>58. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>59. Signature of Burial: <u>U.S.A.</u></p> | | <p>60. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>61. Signature of Burial: <u>U.S.A.</u></p> | | <p>62. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>63. Signature of Burial: <u>U.S.A.</u></p> | | <p>64. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>65. Signature of Burial: <u>U.S.A.</u></p> | | <p>66. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>67. Signature of Burial: <u>U.S.A.</u></p> | | <p>68. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>69. Signature of Burial: <u>U.S.A.</u></p> | | <p>70. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>71. Signature of Burial: <u>U.S.A.</u></p> | | <p>72. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>73. Signature of Burial: <u>U.S.A.</u></p> | | <p>74. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>75. Signature of Burial: <u>U.S.A.</u></p> | | <p>76. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>77. Signature of Burial: <u>U.S.A.</u></p> | | <p>78. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>79. Signature of Burial: <u>U.S.A.</u></p> | | <p>80. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>81. Signature of Burial: <u>U.S.A.</u></p> | | <p>82. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>83. Signature of Burial: <u>U.S.A.</u></p> | | <p>84. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>85. Signature of Burial: <u>U.S.A.</u></p> | | <p>86. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>87. Signature of Burial: <u>U.S.A.</u></p> | | <p>88. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>89. Signature of Burial: <u>U.S.A.</u></p> | | <p>90. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>91. Signature of Burial: <u>U.S.A.</u></p> | | <p>92. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>93. Signature of Burial: <u>U.S.A.</u></p> | | <p>94. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>95. Signature of Burial: <u>U.S.A.</u></p> | | <p>96. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>97. Signature of Burial: <u>U.S.A.</u></p> | | <p>98. Signature of Interment: <u>U.S.A.</u></p> | |
| <p>99. Signature of Burial: <u>U.S.A.</u></p> | | <p>100. Signature of Interment: <u>U.S.A.</u></p> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04983

5069 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing | | c. LENGTH OF STAY IN Ib X Lonaconing | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jackson Street | | d. STREET ADDRESS Jackson Street | |
| 3. NAME OF DECEASED (Type or print) Ida First Beeman Middle Beeman Last | | 4. DATE OF DEATH May Month 6 Day 19 Year 59 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH January 5, 1897 |
| 9. AGE (In years last birthday) 62 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) house work | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (State or foreign country) Midland, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Matthew Kiddy | | 14. MOTHER'S MAIDEN NAME Annie Stark | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Richard Beeman Address Lonaconing, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart 260x DUE TO Diabetes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Obesity DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity | | INTERVAL BETWEEN ONSET AND DEATH 6 wks 3 y | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 18, 1959 to May 4, 1959 , that I last saw the deceased alive on May 4, 1959 , and that death occurred at 2 P.M. from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) Lonaconing, Md. DATE SIGNED May 11 '59 | |
| ACTUAL SIGNATURE George Vash M.D. | | | |
| PHYSICIAN'S NAME (Type) George Vash | | | |
| 22a. BURIAL, CREMATION, or other disposition (Specify) Burial | 22b. DATE THEREOF 5/9/59 | 22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery | 22d. LOCATION (City, town, or county) (State) Lonaconing, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn ADDRESS Lonaconing, Md. | | 24a. REC'D BY REGISTRAR MAY 11 '59 24b. REGISTRAR'S SIGNATURE Arthur L. Hanks | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4992

CERTIFICATE OF DEATH

Reg. Dist. No. 04986

| | | | | | | | | | |
|---|--|---|---|---|--|---|---|---|--|
| 1. PLACE OF DEATH o. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | | c. LENGTH OF STAY IN lb 42 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital | | | | d. STREET ADDRESS 100 Laing Ave | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Alfred Middle Last Benny | | | | 4. DATE OF DEATH Month May Day 29 Year 1959 | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May 12, 1887 | | | |
| 9. AGE (In years last birthday) 72 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Hours Min. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Gardener | | | 10b. KIND OF BUSINESS OR INDUSTRY Self Employed | | 11. BIRTHPLACE (State or foreign country) Hungary | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | INFORMANT Address Wife Myrtle Benny, Cumberland, Md. | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Gallbladder with widespread metastases 155.1 DUE TO metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 year | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 4 - 24 , 19 59 , to 5 - 28 , 19 59 , that I last saw the deceased alive on 5 - 28 , 19 59 , and that death occurred at 11:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 62 Greene St. DATE SIGNED 5 - 30 - 59 | | | | | | | | | |
| ACTUAL SIGNATURE R. W. Ballin | | | | M.D. 62 Greene St. | | | | DATE SIGNED 5 - 30 - 59 | |
| PHYSICIAN'S NAME (Type) R.W. Ballin, M.D. | | | | Cumberland, Md. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-1-1959 | | 22c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery | | 22d. LOCATION (City, town, or county) (State) Cumberland, Md. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md. | | | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE JUN 5 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

04988

CERTIFICATE OF DEATH

1993

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4993 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | c. LENGTH OF STAY IN 1b 6 DAYS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) James First BABY Middle ROBERT Last BOY BIBLE, JR. | | 4. DATE OF DEATH Month MAY Day 13 Year 1959 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAY 7, 1959 |
| 9. AGE (In years last birthday) yrs. | | 10. IF UNDER 1 YEAR Months 6 Days 6 Hours 6 Min. | 11. IF UNDER 24 HRS. Months 6 Days 6 Hours 6 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JAMES R. BIBLE | | 14. MOTHER'S MAIDEN NAME JOANN MULLENAX | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| INFORMANT WARWICK & MEMORIAL AVENUE | | MEMORIAL HOSPITAL - CUMBERLAND, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO Prematurity 24-26 wks Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 7 mon , 19 59 , to 13 mon , 19 59 , that I last saw the deceased alive on 12 mon , 19 59 , and that death occurred at 3:22 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Dr. F. B. Whitworth M.D. | | ADDRESS (Street, city or town, state) Cumberland Md. DATE SIGNED 13 mon 59 | |
| PHYSICIAN'S NAME (Type) DR. F. B. WHITWORTH | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 5/14/59 | 22c. NAME OF CEMETERY OR CREMATORY Glendale Bethel | 22d. LOCATION (City, town, or county) (State) Flintstone, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE John F. Hafer | | 24. REC'D BY REGISTRAR MAY 15 '59 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04988

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

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|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | c. LENGTH OF STAY IN 1b 6 DAYS | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL | | d. STREET ADDRESS 1 138 N. CENTRE STREET | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First LAWRENCE Middle F. Last BOCK | 4. DATE OF DEATH Month MAY Day 13 Year 19 59. | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH APRIL 21, 1899 |
| 9. AGE (in years last birthday) 60 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER- SELF EMPLOYED | | 10b. KIND OF BUSINESS OR INDUSTRY CUMBERLAND, MARYLAND | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
| 13. FATHER'S NAME LEONARD J. BOCK | | 14. MOTHER'S MAIDEN NAME CHARLOTTE STARNER | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk. | 16. SOCIAL SECURITY NO. | 17. INFORMANT WARWICK & MEMORIAL AVES. MEMORIAL HOSPITAL - CUMBERLAND, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH 7 DAYS |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <i>Benedict Skitarelic</i> | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED |
| EXAMINER'S NAME (Type) DR. BENEDICT SKITARELIC | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | MAY KX 13, 1959 |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 5-15-1959 | 22c. NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul | 22d. LOCATION (City, town, or county) (State) Cumberland, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George | | 24a. REC'D BY REGISTRAR DATE MAY 18 '59 | 24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i> |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

01958

NEW YORK STATE DEPARTMENT OF HEALTH - BATHING
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| <p>NAME OF DECEASED [REDACTED]</p> | | <p>AGE [REDACTED]</p> | |
| <p>SEX [REDACTED]</p> | | <p>RACE [REDACTED]</p> | |
| <p>DATE OF DEATH [REDACTED]</p> | | <p>TIME OF DEATH [REDACTED]</p> | |
| <p>PLACE OF DEATH [REDACTED]</p> | | <p>CAUSE OF DEATH [REDACTED]</p> | |
| <p>DIAGNOSIS [REDACTED]</p> | | <p>DATE OF EXAMINATION [REDACTED]</p> | |
| <p>SIGNATURE OF EXAMINER [REDACTED]</p> | | <p>DATE OF SIGNATURE [REDACTED]</p> | |

CERTIFICATE OF DEATH

04989

Reg. Dist. No.

| | | | |
|---|-------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | c. LENGTH OF STAY IN 1b 31 Days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First John Middle William Last Boone | | 4. DATE OF DEATH Month May Day 22 Year 19 59 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/2/74 |
| 9. AGE (In years last birthday) 84 yrs. | | IF UNDER 1 YEAR Months 84 Days 84 Hours 84 Min. 84 | IF UNDER 24 HRS. Months 84 Days 84 Hours 84 Min. 84 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY Self | |
| 11. BIRTHPLACE (State or foreign country) West Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Samuel Boone | | 14. MOTHER'S MAIDEN NAME Martha Bobo | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. unknown | |
| 17. INFORMANT Homer Boone | | Address Cumberland, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422 Chronic Myocardial Degeneration DUE TO 442X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 592 Chronic Nephritis DUE TO 450 General arteriosclerosis (c) 304 Simple psychosis | | INTERVAL BETWEEN ONSET AND DEATH ? ? ? | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Apr. 15, 19 59 , to May 22, 19 59 , that I last saw the deceased alive on May 21, 19 59 , and that death occurred at M. , from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED | |
| ACTUAL SIGNATURE James E. McLean M.D. | | PHYSICIAN'S NAME (Type) James E. McLean, M.D. 49 Greene St., Cumberland, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF May 25, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY Millercrest Burial Park | | 22d. LOCATION (City, town, or county) (State) Cumberland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight ADDRESS Cumberland, Md. | | 24a. REC'D BY REGISTRAR MAY 25 '59 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Hanna | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | c. LENGTH OF STAY IN lb 2 DAYS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL AND WARWICK AVENUES | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First CHARLES Middle A Last BRIDGES | | 4. DATE OF DEATH Month MAY Day 28 Year 19 59 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH SEPT 4, 1876 |
| 9. AGE (In years last birthday) 82 yrs. | | 10. IF UNDER 1 YEAR Months 02 Days 00 Hours 00 Min. 00 | 11. IF UNDER 24 HRS. Hours 00 Min. 00 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Sawmill Wkr | |
| 11. BIRTHPLACE (State or foreign country) BEANS COVE, PENNSYLVANIA | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME ABRAHAM BRIDGES | | 14. MOTHER'S MAIDEN NAME MARGARET ELLIOTT | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 175-16-8441 | |
| 17. INFORMANT MEMORIAL HOSPITAL | | Address CUMBERLAND, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) mesenteric thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis (c) Arteriosclerotic Heart Disease | | | INTERVAL BETWEEN ONSET AND DEATH 48 hrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from May 7, 1959 , to May 28, 1959 , that I last saw the deceased alive on May 28, 1959 , and that death occurred at 3:10 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE William O. Jones | | DATE SIGNED 5-29-59 | |
| PHYSICIAN'S NAME (Type) DR. W. P. JAMES | | Cumberland, Md | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF MAY 30, 1959 | 22c. NAME OF CEMETERY OR CREMATORY Beans Cove Meth. Cem. | 22d. LOCATION (City, town, or county) (State) Allegany Co., Md |
| 23. FUNERAL DIRECTOR'S SIGNATURE John J. Hager, Cumberland, Md | | 24a. REC'D BY REGISTRAR DATE JUN 3 '59 | 24b. REGISTRAR'S SIGNATURE Arthur E. Hanes |

4
Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

04390

CERTIFICATE OF DEATH

ALLIANCE

EMERALD

WILLOW

ELKSTONE

5 DAYS

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4997

CERTIFICATE OF DEATH

Reg. Dist. No.

04991

| | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Allegany | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | c. LENGTH OF STAY IN 1b Lifetime | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY Allegany | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Cumberland | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 329 Race Street | | | | | | d. STREET ADDRESS 329 Race Street | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Helene | | Middle Marcella | | Last Bridges | | 4. DATE OF DEATH Month May | | Day 12, | | Year 1959 | |
| 5. SEX F | | 6. COLOR OR RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH June 12, 1916 | | 9. AGE (In years last birthday) 42 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Previous Mech. Operator | | | | 10b. KIND OF BUSINESS OR INDUSTRY Textile Indstry | | 11. BIRTHPLACE (State or foreign country) Cumberland, Md. | | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Sylvester Pittman | | | | | | 14. MOTHER'S MAIDEN NAME Dora Elizabeth Schade | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 214-07-4350 | | 17. INFORMANT Address Mr. Luke M. Bridges, Cumberland, Md. | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus DUE TO (c) Arteriosclerosis | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 33 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) Jan. | | (County) (State) | |
| 21. I certify that I attended the deceased from Jan. 1959 to May 12, 1959 , that I last saw the deceased alive on Apr. 15, 1959 , and that death occurred at 5:40 M, from the causes and on the date stated above. | | | | | | | | | | | |
| ACTUAL SIGNATURE Clay E. Durrett | | | | | | ADDRESS (Street, city or town, state) 236 Virginia Ave. Cumberland, Md. | | | | | |
| PHYSICIAN'S NAME (Type) Clay E. Durrett | | | | | | DATE SIGNED May 14 1959 | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5-15-59 | | 22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park | | | | 22d. LOCATION (City, town, or county) (State) Cumberland, Md. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli | | | | | | ADDRESS Cumberland, Md. | | 24a. REC'D BY REGISTRAR DATE MAY 14 1959 | | 24b. REGISTRAR'S SIGNATURE Arthur L. House | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1901

Case No. 100

| | | | | | |
|---|--|--|--|--|--|
| 1. NAME OF DECEASED JAMES M. JONES | | 2. SEX Male | | 3. AGE 45 | |
| 4. DATE OF DEATH Jan 15 1901 | | 5. TIME OF DEATH 10:30 AM | | 6. PLACE OF DEATH Home | |
| 7. CAUSE OF DEATH Heart Disease | | 8. DISEASE OR INJURY Myocardial Infarction | | 9. MANNER OF DEATH Natural | |
| 10. SIGNATURE OF PHYSICIAN J. M. Jones | | 11. SIGNATURE OF WITNESSES J. M. Jones, J. M. Jones | | 12. SIGNATURE OF DECEASED J. M. Jones | |
| 13. SIGNATURE OF REGISTRAR J. M. Jones | | 14. SIGNATURE OF CLERK J. M. Jones | | 15. SIGNATURE OF NOTARY J. M. Jones | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04992

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|------------------------------|--|---|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> | | c. LENGTH OF STAY in 1b <u>20yrs</u> | | X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. Memorial Hospital</u> | | | | d. STREET ADDRESS <u>#4-H-Jane Frazer Village</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Roy H. Broll (Jack Corbett)</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>14</u> , Year <u>1959</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED: <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb. 4, 1896</u> | | 9. AGE (In years last birthday) <u>63</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Orchard Fruit</u> | | 11. BIRTHPLACE (State or foreign country) <u>Hardy County W. Va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Wm. H. Broll</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sally Self</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | | 16. SOCIAL SECURITY NO. <u>213-12-9666</u> | | 17. INFORMANT <u>Beulah Corbett #4-H Jane Frazer Village</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Sclerosis</u> (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 14, 1959</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5-17-59</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Olivet Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Moorefield, W. Va.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u> <u>Cumberland, Md.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>MAY 15 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

WYOMING STATE DEPARTMENT OF HEALTH - BATHING 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11-20-20

| | | | | | | | | | | | |
|----------------------|--|---------------------------------|--|----------------------|--|-----------------|--|---------------------------------|--|-------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF DEATH | | PLACE OF DEATH | |
| JAMES H. HARRIS | | 45 | | M | | W | | 11-20-20 | | HOME | |
| RESIDENCE | | OCCUPATION | | CAUSE OF DEATH | | MANNER OF DEATH | | SIGNATURE OF EXAMINER | | DATE | |
| 1000 1/2 N. 10th St. | | Farmer | | Heart Disease | | Natural | | J. H. HARRIS | | 11-20-20 | |
| PREVIOUS ILLNESS | | SYMPTOMS | | TREATMENT | | POST-MORTEM | | FINDINGS | | REMARKS | |
| None | | Chest pain, shortness of breath | | Medicine, rest | | None | | Lungs congested, heart enlarged | | No other findings | |
| FAMILY HISTORY | | SOCIAL HISTORY | | EDUCATION | | RELIGION | | MARRIAGE | | CHILDREN | |
| None | | None | | High School | | Methodist | | Married | | 3 | |
| DECEASED'S SIGNATURE | | WITNESSES' SIGNATURES | | EXAMINER'S SIGNATURE | | OFFICIAL SEAL | | NOTARY PUBLIC | | DATE | |
| J. H. HARRIS | | J. H. HARRIS, J. H. HARRIS | | J. H. HARRIS | | [Seal] | | J. H. HARRIS | | 11-20-20 | |



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE WYOMING DEPARTMENT OF HEALTH. IT IS NOT VALID FOR ANY OTHER PURPOSE. IT IS NOT VALID FOR ANY OTHER PURPOSE. IT IS NOT VALID FOR ANY OTHER PURPOSE.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04993

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|----------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Allegany 5070 MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Mary's Cemetery RD | | c. LENGTH OF STAY IN 1b 4-Lifetime | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Cemetery RD 4 Oldtown Rd. | | | | d. STREET ADDRESS 25 Oak Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Leo Middle Joseph Last Buskey | | | | 4. DATE OF DEATH Month May Day 24 Year 1959 | | | |
| 5. SEX Male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 10, 1902 | | 9. AGE (in years last birthday) 56 yrs. | IF UNDER 1 YEAR Months 24 Days 24 | IF UNDER 24 HRS. Hours 24 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Pipefitter | | 10b. KIND OF BUSINESS OR INDUSTRY Textile | | 11. BIRTHPLACE (State or foreign country) Cumberland, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME George Buskey | | | | 14. MOTHER'S MAIDEN NAME Katherine Decker | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 214-07-4044 | | 17. INFORMANT Address Mrs. Leo J. Buskey, Cumberland, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary Sclerosis (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH Sudden ----- | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Benedict Skitarelic M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 24, 1959 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5-27-1959 | | 22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery | | 22d. LOCATION (City, town, or county) (State) Cumberland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md. | | | | 24a. REC'D BY REGISTRAR DATE MAY 26 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. House | |

0-303

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT

6070



RECEIVED
BALTIMORE, MD
JAN 10 1918

Form with multiple sections for medical examination, including fields for name, age, sex, race, occupation, and cause of death. The form is filled out with handwritten information.

NAME: [Handwritten Name]
AGE: [Handwritten Age]
SEX: [Handwritten Sex]
RACE: [Handwritten Race]
OCCUPATION: [Handwritten Occupation]
CAUSE OF DEATH: [Handwritten Cause of Death]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04994

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|--|----------------------------------|--|--|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Allegany 5053 MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W.Va. b. COUNTY Mineral | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport | | c. LENGTH OF STAY IN 1b 3 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Piedmont 85 X-3 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Waverly St. | | | | d. STREET ADDRESS Jones & Orchard St. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Clara Middle Dale Last Butler | | | | 4. DATE OF DEATH Month May Day 14 Year 19 59 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 57 yrs. | | 9. AGE (In years last birthday) 57 | 10. IF UNDER 1 YEAR Months 57 Days 14 Hours 19 Min. 59 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife | | 10b. KIND OF BUSINESS OR INDUSTRY W.Va. | | 11. BIRTHPLACE (State or foreign country) U.S.A | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 13. FATHER'S NAME Dillon Leatherman | | | | 14. MOTHER'S MAIDEN NAME Fannie Newhouse | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Va. Strickler, Westernport, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertension (c) 2 years DUE TO (a) 331X (b) 331X (c) 331X causes lost. | | | | | | INTERVAL BETWEEN ONSET AND DEATH Sudden 2 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE WOMcLane | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED May 14 1959 | | | |
| EXAMINER'S NAME (Type) WOMcLANE MD | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/16/59 | | 22c. NAME OF CEMETERY OR CREMATORY Philos Cemetery | | 22d. LOCATION (City, town, or county) (State) Westernport Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. H. Hudlock Jr | | | | ADDRESS Piedmont, W.Va. | | 24a. REC'D BY REGISTRAR MAY 18 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. K... | | | |

4999

CERTIFICATE OF DEATH

04995

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | | | c. LENGTH OF STAY IN lb 9 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL | | | | e. STREET ADDRESS ROUTE #2 | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First CLARA Middle G. Last CLEVELAND | | | | 4. DATE OF DEATH Month MAY Day 6 Year 19 59 | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH JUNE 6, 1874 | |
| 9. AGE (In years last birthday) yrs. 84 | | 10. IF UNDER 1 YEAR Months 84 Days 84 Hours 84 Min. 84 | | 11. IF UNDER 24 HRS. Months 84 Days 84 Hours 84 Min. 84 | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME COLUMBUS RICE | | | | 14. MOTHER'S MAIDEN NAME EMMA HAMILTON | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. None | | | |
| 17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND | | | | 18. ADDRESS WARWICK & MEMORIAL AVENUE | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Cerebral sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral sclerosis (c) Cerebral sclerosis | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary emphysema (b) Bronchitis (c) Legionnaires | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19 | | | | | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 5/5/59 , 19 59 , to 5/5/59 , 19 59 , that I last saw the deceased alive on 5/5/59 , 19 59 , and that death occurred at 2:40AM , from the causes and on the date stated above. | | | | | | | |
| 22. ADDRESS (Street, city or town, state) DATE SIGNED 704 Montgomery Ave, Cumberland Md 5/6/59 | | | | | | | |
| ACTUAL SIGNATURE DR. REES | | | | | | | |
| PHYSICIAN'S NAME (Type) DR. REES | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | | |
| 22b. DATE THEREOF 5/8/1959 | | | | | | | |
| 22c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cemetery | | | | | | | |
| 22d. LOCATION (City, town, or county) (State) Cumberland, Md. | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Byron Kight Cumberland, Md. | | | | | | | |
| 24a. REC'D BY REGISTRAR DATE MAY 7 '59 | | | | | | | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kight | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00003

CERTIFICATE OF DEATH

1909

ALBANY

WHITE

WHITE

ROUTE 10

2 DAYS

2 DAYS

THE CITY HOSPITAL

CLEVELAND

CLARA

ONE 1/2

WHITE

WHITE

ONE 1/2

ONE 1/2

THE CITY HOSPITAL - CLEVELAND, OHIO
DIVISION OF VITAL RECORDS

5000

CERTIFICATE OF DEATH

04996

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | c. LENGTH OF STAY IN lb 8 DAYS | |
| d. NAME OF HOSPITAL (If in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES., | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First ALBERTA Middle LOUISE Last CONRAD | | 4. DATE OF DEATH Month May Day 19 Year 1959 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JANUARY 27, 1959 |
| 9. AGE (In years last birthday) 4 | | 10. IF UNDER 1 YEAR Months 4 Days 19 Hours 19 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME DONALD E. CONRAD | | 14. MOTHER'S MAIDEN NAME ANNA JEANORA WEIMER | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Respiratory Infection 527.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Concurrent Hydrocephalus. Spina Bifida. INTERVAL BETWEEN ONSET AND DEATH 5-10-59 | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 5-11-59 to 5-19-59 , that I last saw the deceased alive on 5-19-59 , and that death occurred at 10:02 AM on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Hyndman, Pa. RD#1 ACTUAL SIGNATURE H. H. Ellison M.D. 126 Hyndman, Pa. RD#1 PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF May 21, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY Comps Cemetery | | 22d. LOCATION (City, town, or county) (State) Hyndman, Pa. RD#1 | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Leigler ADDRESS Hyndman, Pa. | | 24a. REC'D BY REGISTRAR MAY 22 '59 DATE | |
| 24b. REGISTRAR'S SIGNATURE Arthur A. Hume | | | |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

20601828V5

STH:HV 2:453

DEVELOP A PLAN

5001

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|-------------------------------|--|--------------------------------|
| 1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE WEST VIRGINIA b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WILEY FORD 85 x 3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL AND WARWICK AVENUES | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) First ANTHONY Middle A Last DE POMPE | | 4. DATE OF DEATH Month MAY Day 26 Year 19 59 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH SEPT 1 |
| 9. AGE (In years last birthday) 49 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Pinkerton Pa | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME ANTONIO DE POMPE | | 14. MOTHER'S MAIDEN NAME MARY ANN OHLER | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 705-19-0146 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Rt. Lung with Metastases to Liver 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 10:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Algonquin Hotel, Cumberland DATE SIGNED ACTUAL SIGNATURE Calvin Y. Hadidian M.D. Calvin Y. Hadidian PHYSICIAN'S NAME (Type) CALVIN Y. HADIDIAN Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF May 29, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY Int Lion cemetery | | 22d. LOCATION (City, town, or county) (State) Howard County Pa | |
| 23. FUNERAL DIRECTOR'S SIGNATURE William J. Hood ADDRESS Rockwood, Pa. | | 24a. REC'D BY REGISTRAR JUN 2 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Hume | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

04997

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

1901

WEST VIRGINIA

ALLIANCE

WILLY FORD

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CINCINNATI

DEATH AND BURIAL

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1901

WILLY FORD

DEPT 10 DE BOW

CINCINNATI, MO.

MEMORIAL HOSPITAL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG242 5-11-59 et

CERTIFICATE OF DEATH

Reg. Dist. No. **04998**

5002

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|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | c. LENGTH OF STAY IN lb 10 DAYS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL AND WARWICK AVENUES | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First BLANCHE Middle EVANS Last EVANS | | 4. DATE OF DEATH Month MAY Day 2 Year 19 59 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JUNE 8, 1893 |
| 9. AGE (In years last birthday) yrs. 65 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME ROBERT C CAMPBELL | | 14. MOTHER'S MAIDEN NAME ALICE GUARD | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Adeno Carcinoma, Ovarian DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 yr 1-2 yr. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Aug 1, 1958 , to 5-2, 1959 , that I last saw the deceased alive on 5-2, 1959 , and that death occurred at 9:50 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE [Signature] | | ADDRESS (Street, city or town, state) DATE SIGNED 5/3/59 | |
| PHYSICIAN'S NAME (Type) DR. A. J. MIRKIN | | Cumberland, Md | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF May 6, 1959 | 22c. NAME OF CEMETERY OR CREMATORY Hyndman Cemetery | 22d. LOCATION (City, town, or county) (State) Hyndman, Pa. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Heigler, | | ADDRESS Hyndman, Pa. | |
| 24a. REC'D BY REGISTRAR DATE MAY 7 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04999

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Allegany 5054 MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg | | c. LENGTH OF STAY IN 1b X Lonaconing Rural Near Lonaconing | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Minera Hospital | | d. STREET ADDRESS Detmold Street | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Rickey Lee Fairgrieve | | 4. DATE OF DEATH 5/10/1959 Month Day Year | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1/30/1959 |
| 9. AGE (In years last birthday) 3 yrs. 10 Months 10 Days | | IF UNDER 1 YEAR Hours Min. 3 10 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (State or foreign country) Frostburg, MD. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Milton R. Fairgrieve | | 14. MOTHER'S MAIDEN NAME Dolores Petroff | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Milton R. Fairgrieve, Lonaconing, MD. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] (Father) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 902.5 Intercranial Hemorrhage DUE TO (b) Fracture Rt Base Skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Baby was Dropped on Highway | |
| 20c. TIME OF INJURY Month, Day, Year Hour 6:00 p.m. May 10 1959 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work Highway | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Near Lonaconing Allegany MD | | 20f. (City or town) (County) (State) Allegany MD | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE WOM Lane | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) WOM Lane M.D. ant | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED May 12 1959 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/13/1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery | | 22d. LOCATION (City, town, or county) (State) Lonaconing, MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHORN | | ADDRESS LONA CONING, MD. | |
| 24a. REC'D BY REGISTRAR DATE MAY 13 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. House | |

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STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8 & 9, Film G-242 5/13/59 cac

CERTIFICATE OF DEATH

05000

Reg. Dist. No.

| | | | | | |
|--|----------------------------------|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Allegany | | 5055 | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital | | d. STREET ADDRESS Church Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Joseph Middle P. Last Flynn | | 4. DATE OF DEATH Month May Day 1 Year 19 59 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH 1892 July 31, 1891 | 9. AGE (In years last birthday) 66 87 yrs. | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rubber Worker | | 10b. KIND OF BUSINESS OR INDUSTRY Kelly Tire Co | | 11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME John Flynn | | 14. MOTHER'S MAIDEN NAME Mary Shanskey | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 214-16-2046 | | 17. INFORMANT Mrs. Lawrence Rooney Address Lonaconing, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Abdominal Carcinomatosis DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 2 weeks 5 months | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that I attended the deceased from April 12, 1959 , to April 30, 1959 , that I last saw the deceased alive on April 30, 1959 , and that death occurred at 5:10 AM , from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE Mikio Kato | | ADDRESS (Street, city or town, state) 51 Main St. Lonaconing, Md. | | DATE SIGNED 5/1/59 | |
| PHYSICIAN'S NAME (Type) MIKIO KATO | | | | | |
| 22a. BURIAL, CREMATION, or other disposal (Specify) Burial | | 22b. DATE THEREOF 5/4/59 | | 22c. NAME OF CEMETERY OR CREMATORY St Marys Cemetery | |
| 22d. LOCATION (City, town, or county) (State) Lonaconing, Md. | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn | | ADDRESS Lonaconing, Md. | | 24a. REC'D BY REGISTRAR MAY 4 '59 | |
| 24b. REGISTRAR'S SIGNATURE Arthur E. Hanna | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

645-01-112

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05001

Reg. Dist. No.

5003

FOR STATE
HEALTH DEPT.

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Grant c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Petersburg 85X-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Paul Victor George | | 4. DATE OF DEATH Month Day Year May 27 1959 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 2, 1958 |
| 9. AGE (In years last birthday) 1 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) Petersburg, W. Va. | | 12. CITIZEN OF WHAT COUNTRY? Usa | |
| 13. FATHER'S NAME Paul Victor George, Senior | | 14. MOTHER'S MAIDEN NAME Ollie C. Woods | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Memorial Hospital, Cumberland, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Perforation of stomach (digestion) 752x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral edema and pressure DUE TO (c) Hydrocephalus, Moderate (probably congenital) INTERVAL BETWEEN ONSET AND DEATH 2 days. 2-3 days. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Benedict Skitarelic | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIED | | 22b. DATE THEREOF MAY-29-1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY MAPLEHILL CEMETERY | | 22d. LOCATION (City, town, or county) (State) PETERSBURG - WVA | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. Shaw Schaffer | | 24. REC'D BY REGISTRAR DATE JUN 4 '59 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

05002

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Allegany 5004 MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Allegheny | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | c. LENGTH OF STAY IN 1b 75X-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital | | d. STREET ADDRESS Toner Institute | |
| 3. NAME OF DECEASED (Type or print) (Father) Louis Glantz | | 4. DATE OF DEATH Month May Day 23 Year 1959 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 27, 1913 |
| 9. AGE (In years last birthday) 45 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clergyman | | 10b. KIND OF BUSINESS OR INDUSTRY Priest | 11. BIRTHPLACE (State or foreign country) Pa. |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME August Glantz | |
| 14. MOTHER'S MAIDEN NAME Catherine Schwab | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | |
| 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Sacred Heart Hosp. Cumb. Md | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 1958 , 19____, to 5/23 , 19 59 , that I last saw the deceased alive on 5/23 , 19 59 , and that death occurred at 9:45 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Leo H. Ley Jr. | | M.D. 456 N. Centre St. 5/25/59 | |
| PHYSICIAN'S NAME (Type) LEO H. LEY JR. | | Cumberland Md | |
| 22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial | 22b. DATE THEREOF 5/27/59 | 22c. NAME OF CEMETERY OR CREMATORY St. Augustine Cem. | 22d. LOCATION (City, town, or county) (State) Millvale Penna |
| 23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. | | ADDRESS Cumberland Md | |
| 24a. REC'D BY REGISTRAR DATE JUN 1 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Hanna | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05908

CERTIFICATE OF DEATH

1

NAME

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF CREMATION

PLACE OF CREMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF EXHUMATION

PLACE OF EXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5005 CERTIFICATE OF DEATH

05003

Reg. Dist. No.

| | | | |
|--|------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | c. LENGTH OF STAY IN 1b 1/31/59 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Sarah Grace Graham | | 4. DATE OF DEATH Month Day Year May 30 19 59 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6/4/1882 |
| 9. AGE (In years last birthday) 76 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (State or foreign country) Maryland, Altamont | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Benjamin B. Cassidy | | 14. MOTHER'S MAIDEN NAME Katherine Hoy | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT P.O. Box 599 | | Address Cumberland, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) Chronic myocardial degeneration | | INTERVAL BETWEEN ONSET AND DEATH ? ? ? | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Gastritis | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1/31/59 19____, to 5/30/59 19____, that I last saw the deceased alive on 5/30/59 19____, and that death occurred at 7:40 P. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE James E. McLean | | ADDRESS (Street, city or town, state) DATE SIGNED 49 Greene Street 6/1/59 | |
| PHYSICIAN'S NAME (Type) Dr. James E. McLean | | Cumberland, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 6/2/59 | 22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park | 22d. LOCATION (City, town, or county) (State) Cumberland, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland | | 24a. REC'D BY REGISTRAR DATE JUN 3 '59 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kiana | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. *Journal of the American Medical Association*, 1964; 191: 1000-1001.

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03

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01/05/01

THOMAS E. NIELSEN

REF. NO. 0-5-2

Allegany County, Maryland

22/2/1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05004

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Allegany 5006 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b DOA | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland d. STREET ADDRESS 524 Shriver Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) WILAVENE First JUANITA Middle GR IFFITH Last 4. DATE OF DEATH May Month 31 Day 19 Year 1959 | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH March 17, 1924 | | 9. AGE (In years last birthday) 35 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier | | 12. KIND OF BUSINESS OR INDUSTRY A & P Super Mkt. | | 13. BIRTHPLACE (State or foreign country) Waynesburg, Pennsylvania | |
| 14. CITIZEN OF WHAT COUNTRY USA | | | | | |
| 15. FATHER'S NAME E. Floyd Breese | | 16. MOTHER'S MAIDEN NAME Clara Bell Camp (Deceased) | | | |
| 17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 18. SOCIAL SECURITY NO. 217-18-4565 | | 19. INFORMANT Charles E. Griffith 524 Shriver Avenue Cumberland, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRACRANIAL HEMORRHAGE 823X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SKULL FRACTURE DUE TO (c)</p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH SUDDEN SUDDEN</p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) AUTO STRUCK UTILITY POLE</p> | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) AUTO STRUCK UTILITY POLE | | | |
| 20c. TIME OF INJURY Month, Day, Year 1:40 a.m. May 31 '59 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street | |
| 20f. (City or town) Cumberland, Alleg. Md. | | 20g. (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE Benedict Skitarelio M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) Benedict Skitarelio, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF June 3, 1959 | | 22c. NAME OF CEMETERY OR CREMATORY St. Mary's Catholic Cemetery | |
| 22d. LOCATION (City, town, or county) Cumberland, Maryland | | 22e. (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland | | 24a. REC'D BY REGISTRAR JUN 3 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

1. The first of these is the fact that the system is not a simple one. It is a complex system, and the results of the analysis are not always clear. The system is not a simple one, and the results of the analysis are not always clear.

05005

VS A15 (4)
15M 9/58

| | | | | | |
|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | ALLEGANY | | MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | CUMBERLAND, MD. | | c. LENGTH OF STAY IN 1b 12 DAYS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | MEMORIAL HOSPITAL | | | |
| 3. NAME OF DECEASED (Type or print) | | First OLIVER | | Middle W. Last GROSS | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH NOVEMBER 24, | | 9. AGE (In years last birthday) 74 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | RETIRED Painter | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME CHARLES GROSS | | 14. MOTHER'S MAIDEN NAME ETTA GRANT | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. 215-18-8752 | | INFORMANT WARWICK & MEMORIAL AVENUE MEMORIAL HOSPITAL - CUMBERLAND, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO (b) Myocardial Infarction DUE TO (c) Arteriosclerosis Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH 2 days 3 years 3 years | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 18 Apr 1959, to 1 May 1959, that I last saw the deceased alive on 30 Apr 1959, and that death occurred at 1:25 AM, from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) 707 West Main St Cumberland, Md | | DATE SIGNED MAY 4 '59 | |
| ACTUAL SIGNATURE DR. REES | | PHYSICIAN'S NAME (Type) DR. REES | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF 5/3/59 | | 22c. NAME OF CEMETERY OR CREMATORY Mt. Vernon Cem. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Louis Star Inc. | | ADDRESS Cumb. Md. | | 24a. REC'D BY REGISTRAR DATE MAY 4 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Jones | |

05003

STATE OF DEATH

NAME

RESIDENCE

DATE

TIME

CAUSE OF DEATH

PLACE OF DEATH

SEX

AGE

DATE OF BIRTH

TIME

1.2.3

WEST VIRGINIA

DECEASED

DATE OF DEATH

DECEASED

WEST VIRGINIA

DECEASED

DECEASED

2.2.2

05006

Reg. Dist. No.

| | | | | | | | | | | | | | | | | | |
|---|--|---------------------------|--|---|--|---|--|--|--|-----------------------------------|--|---------------------------------------|--|--------------------------------------|--|-----------------|--|
| 1. PLACE OF DEATH a. COUNTY | | Allegany | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE | | Maryland | | b. COUNTY | | Allegany | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | Cumberland | | c. LENGTH OF STAY IN lb | | 5/14/56 | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | 02 107 Hanover Street, Cumberland | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | Allegany County Infirmary | | d. STREET ADDRESS | | 1 107 Hanover Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First | | Middle | | Last | | 4. DATE OF DEATH | | Month | | Day | | Year | | | |
| | | William | | F. | | Grubb | | May | | 23, | | 19 | | 59 | | | |
| 5. SEX | | Male | | 6. COLOR OR RACE | | White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 2/25/1876 | | 9. AGE (In years last birthday) yrs. | | 83 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | Retired - Cabinetmaker | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) | | Everitt, Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? | | U. S. A. | | | |
| 13. FATHER'S NAME | | Simon Grubb | | 14. MOTHER'S MAIDEN NAME | | Sabina Chamberland | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | NO | | 16. SOCIAL SECURITY NO. | | NONE | | 17. INFORMANT | | P.O.Box 599 | | Address | | Cumberland, Md. | | | |
| | | | | | | | | | | Allegany County Infirmary Records | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592 X Chronic myocardial degeneration DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General arteriosclerosis DUE TO (c) Chronic nephritis | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | Chronic prostatitis | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. | | Month, Day, Year | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | | | | | |
| 21. I certify that I attended the deceased from May 14, 1956, to May 23, 1959, that I last saw the deceased alive on May 23, 1959, and that death occurred at 4:30 P.M. from the causes and on the date stated above. | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | James E. McLean | | M.D. | | 49 Greene St | | ADDRESS (Street, city or town, state) | | | | DATE SIGNED | | | | | |
| PHYSICIAN'S NAME (Type) | | Dr. James E. McLean | | Cumberland, Md. | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | Burial | | 22b. DATE THEREOF | | May 26, 1959 | | 22c. NAME OF CEMETERY OR CREMATORY | | Rose Hill Cemetery | | 22d. LOCATION (City, town, or county) | | Cumberland, Md. | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | Byron Knight | | ADDRESS | | Cumberland, Md. | | 24a. REC'D BY REGISTRAR | | DATE | | MAY 27 '59 | | 24b. REGISTRAR'S SIGNATURE | | Arthur L. Hines | |

VS A15 (4)
15M 10/57

1552

53

SIAM

at 300.

0702 NEWS

5

continued on page 10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05007

Reg. Dist. No.

1
FOR STATE
HEALTH DEPT.

M

5009

| | | | | | |
|---|---|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Allegany MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | c. LENGTH OF STAY IN 1b 3hrs. | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Confluence 75 x -3 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital | | | d. STREET ADDRESS 622 Williams St. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Earle Middle Thomas Last Hall | | | 4. DATE OF DEATH Month May Day 5 Year 19 59 | | |
| 5. SEX Male | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 11, 1897 | | 9. AGE (In years last birthday) 61 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad | | 10b. KIND OF BUSINESS OR INDUSTRY Fireman | 11. BIRTHPLACE (State or foreign country) Beaver Creek, Pa | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Elisha Hall | | | 14. MOTHER'S MAIDEN NAME Zella Glover | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 163-18-9087 | 17. INFORMANT Wife, Confluence, Pa. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 hr. 6**** |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE Benedict Skitarelic | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED May 5, 1959 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF May, 8, 1959 | 22c. NAME OF CEMETERY OR CREMATORY Johnson Chapel Cemetery | | 22d. LOCATION (City, town, or county) (State) Confluence Fayette Pa. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Samuel A. Black | | ADDRESS Confluence, Pa. | | 24a. REC'D BY REGISTRAR R.D.#2 DATE MAY 8 '59 | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

115002

STATE DEPARTMENT OF HEALTH - BATHING
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT

1933

Allegany

Wheatfield

Wheatfield Hospital

Wheatfield

Wheatfield

Wheatfield, Pa.

Wheatfield

Wheatfield

Wheatfield

Wheatfield, Pa.

Wheatfield, Pa.

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Wheatfield, Pa.

Wheatfield, Pa.

Wheatfield, Pa.

Wheatfield, Pa.

Wheatfield, Pa.

CERTIFICATE OF DEATH

Reg. Dist. No.

05008

5010

| | | | |
|---|------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | c. LENGTH OF STAY IN 1b 4 DAYS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First HELEN Middle Theresa Last HATTON | | 4. DATE OF DEATH Month MAY Day 29 Year 19 59 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH NOVEMBER 29, 1887 |
| 9. AGE (In years last birthday) yrs. 71 | | 10. IF UNDER 1 YEAR: Months 7 Days 1 Hours 1 Min. 1 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own home | |
| 11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME JOHN HARTMAN | | 14. MOTHER'S MAIDEN NAME MARGARET PENDERGAST | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Coronary Sclerosis DUE TO (c) 3 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4 days INTERVAL BETWEEN ONSET AND DEATH 3 yrs | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 3/2/56 , 19___, to 5/29/59 , 19___, that I last saw the deceased alive on 5/29/59 , 19___, and that death occurred at 8:20 A.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE DR. RICHARD J. WILLIAMS | | ADDRESS (Street, city or town, state) DATE SIGNED 5/29/59 | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 6/1/59 | 22c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cem. | 22d. LOCATION (City, town, or county) (State) Cumberland, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George | | ADDRESS Cumberland, Maryland | |
| 24a. REC'D BY REGISTRAR JUN 3 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Harris | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05008

CERTIFICATE OF DEATH

ALLEGANY

WEST VIRGINIA

ALLEGANY

OVERLAND

1912

OVERLAND

100 NORTH CENTRAL STREET

MEMORIAL HOSPITAL
HARRISON & PENNSYLVANIA

MALE

HATTON

HATTON

HELIX

NOVEMBER 21, 1912

WHITE

U.S.A.

OVERLAND, IND.

OVERLAND, IND.

OVERLAND, IND.

ALLEGANY

ALLEGANY

MEMORIAL HOSPITAL - OVERLAND, IND.

ALLEGANY

DR. RICHARD J. WILLIAMS

OVERLAND, IND.

1912

ALLEGANY

5011 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | c. LENGTH OF STAY IN lb 9 DAYS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL | | e. d. STREET ADDRESS BOX 221 | |
| 3. NAME OF DECEASED (Type or print) First GEORGE Middle A Last HAWKINS | | 4. DATE OF DEATH Month MAY Day 1 Year 19 59 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH FEBRUARY 21 |
| 9. AGE (In years last birthday) yrs. 49 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STORE OWNER | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) FROSTBURG, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME RICHARD HAWKINS | | 14. MOTHER'S MAIDEN NAME MARGARET HANNA | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. 220-10-9368 | |
| 17. INFORMANT WARWICK & MEMORIAL AVENUE | | 18. MEMORIAL HOSPITAL - CUMBERLAND, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Myocardial Infarction - failure DUE TO (c) Generalized Atherosclerosis INTERVAL BETWEEN ONSET AND DEATH 6 hrs 4 days 2-3 yrs | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus - Insulin Dependent | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Feb , 19 57 , to 5-1 , 19 59 , that I last saw the deceased alive on 5-1 , 19 59 , and that death occurred at 11:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED William P. James M.D. 441 N. Center St. 5-2-59 | | | |
| ACTUAL SIGNATURE William P. James | | PHYSICIAN'S NAME (Type) DR. WILLIAM P. JAMES | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5-5-59 | 22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park |
| 22d. LOCATION (City, town, or county) Frostburg, Md. | | 22e. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md. | | 24a. REC'D BY REGISTRAR DATE MAY 7 '59 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | |

18

060

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

05010

5012

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|--|-------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 3 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVENUES | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND d. STREET ADDRESS 111 S SMALLWOOD STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First WILLIAM Middle L Last HOFFMAN | | 4. DATE OF DEATH Month MAY Day 11 Year 19 59 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH FEB 5 1884 |
| 9. AGE (In years last birthday) 75 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY Rail Express | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JOHN C HOFFMAN | | 14. MOTHER'S MAIDEN NAME AMANDA CRANKAY | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 600.0 IMMEDIATE CAUSE (a) Chronic pyelonephritis - Nephrosclerosis DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Benign hyperplastic prostate, chronic prostatitis, arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter notice of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 5-8-59 to 5-11-59 , that I last saw the deceased alive on 5-11-59 , and that death occurred at 9:00 P.M. from the causes and on the date stated above. ADDRESS (street, city or town, state) Cumberland, Md. DATE SIGNED Howard Tolson ACTUAL SIGNATURE Howard Tolson M.D. PHYSICIAN'S NAME (Type) DR. HOWARD TOLSON | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 5-14-1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY HillCrest Cem. | | 22d. LOCATION (City, town, or county) (State) Cumberland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George ADDRESS Cumberland, Md. | | 24a. REC'D BY REGISTRAR DATE MAY 15 '59 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

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VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1950

CERTIFICATE OF DEATH

1112 SMALLWOOD STREET

MAY

HOBOKEN

WILLIAM

WHITE

MALE

WHITE BRANNEY

JOHN C. HOBOKEN

Chronic pyelonephritis & Nephrosis

Comp. suppurative pyelitis, chronic, bilateral, with abscesses

2-8-52 2-11-52

Camper/and, M.D.

Heavenly Father

DR. HOWARD TOLSON

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05011

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | |
|---|------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY 5013 Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | c. LENGTH OF STAY IN 1b 22 hrs. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital | | d. STREET ADDRESS 737 National Highway | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) William Horton | | 4. DATE OF DEATH Month May Day 15 Year 1959 | |
| 5. SEX Male | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 3, 1884 |
| 9. AGE (In years last birthday) 74 yrs. | | 10. IF UNDER 1 YEAR Months 74 Days 0 Hours 0 Min. 0 | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 12. KIND OF BUSINESS OR INDUSTRY Miner | |
| 13. BIRTHPLACE (State or foreign country) Maryland | | 14. CITIZEN OF WHAT COUNTRY? USA | |
| 15. FATHER'S NAME Isiah Horton | | 16. MOTHER'S MAIDEN NAME Anna May Artin | |
| 17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No | | 18. SOCIAL SECURITY NO. 214-01-37992 | |
| 19. INFORMANT Sacred Heart Hosp, Cumberland, Md. | | 20. ADDRESS | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary Sclerosis (c), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture right femoral neck INTERVAL BETWEEN ONSET AND DEATH Sudden | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. XX | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down 3 steps at home | |
| 20c. TIME OF INJURY Month, Day, Year 2:00 P.M. May 14, 1959 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | | 20f. (City or town) (County) (State) Lavale, ZCn Allegany, Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Benedict Skitarelic | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.M | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED May 15, 1959 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5-18-1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Pk. | | 22d. LOCATION (City, town, or county) (State) Frostburg Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Harer Funeral Home Frostburg Md. | | 24a. REC'D BY REGISTRAR DATE MAY 20 '59 | |
| 24b. REGISTRAR'S SIGNATURE Arthur L. Harris | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

05011

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH USE

2013

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Form with multiple sections for medical examination, including fields for name, date of birth, sex, race, and cause of death. The form is oriented horizontally but contains vertical text and checkboxes.

Vertical text on the right margin, likely a filing or processing stamp.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05012

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Book of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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|--|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Allegany 5056 MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg | |
| c. LENGTH OF STAY IN TB 15 hrs. | | d. STREET ADDRESS 68 W. Main St. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) CHARLES S. JEFFRIES | | 4. DATE OF DEATH Month May Day 28 Year 19 59 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 7, 1877 |
| 9. AGE (In years last birthday) 81 yrs. | | 10. IF UNDER 1 YEAR Months 24 Days 19 Hours 59 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired broker | | 10b. KIND OF BUSINESS OR INDUSTRY Coal | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Samuel Jeffries | | 14. MOTHER'S MAIDEN NAME Susan Hocking | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 220-16-2682 | |
| 17. INFORMANT George Jeffries, Frostburg, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial insufficiency 903.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio Vascular Disease DUE TO (c) fracture Neck Left Femur | | INTERVAL BETWEEN ONSET AND DEATH 24 hrs Several years 5 mo | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on icy sidewalk injuring L. Femur | |
| 20c. TIME OF INJURY Month, Day, Year Dec 18 19 58 Hour 11:30 a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street | | 20f. (City or town) (County) (State) Frostburg Allegany Md | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE W O McLane | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) W. O. McLane, M. D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5-30-1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park | | 22d. LOCATION (City, town, or county) (State) Frostburg, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md. | | 24a. REC'D BY REGISTRAR DATE JUN 1 '59 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

FOR STATE
HEALTH DEPT.

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J. W. Hunt, President, Md.

W. O. Holman, N. D.

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W. O. Holman, N. D.

5057 CERTIFICATE OF DEATH

Reg. Dist. No.

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| 1. PLACE OF DEATH o. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital | | d. STREET ADDRESS 124 South Water Street | |
| 3. NAME OF DECEASED (Type or print) First ROSE Middle E. Last JEFFRIES | | 4. DATE OF DEATH Month 5 Day 7 Year 19 59. | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-7-1877 |
| 9. AGE (In years last birthday) 81 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | 10b. KIND OF BUSINESS OR INDUSTRY Own home | |
| 11. BIRTHPLACE (State or foreign country) Borden Mines | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Christian Spitznas | | 14. MOTHER'S MAIDEN NAME Rosella Schurman | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT James P. Jeffries, Rt. #2, Box 42, | | Address Frostburg, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyertensive Cardio - 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Vascular disease DUE TO (c) Senility | | | INTERVAL BETWEEN ONSET AND DEATH 10 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 5-2 , 19 59 , to 5-7 , 19 59 , that I last saw the deceased alive on 5-7 , 19 59 , and that death occurred at 8:10 P.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE H.C. Diehl | | ADDRESS (Street, city or town, state) 39 W. MAIN ST. FROSTBURG, Md. | |
| PHYSICIAN'S NAME (Type) H.C. Diehl M.D. | | DATE SIGNED 5/8/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5-9-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park Frostburg | | 22d. LOCATION (City, town, or county) (State) Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Beulah H. Montrose | | ADDRESS Hafer Funeral Home 23 E. Main, Frostburg, Md. | |
| 24a. REC'D BY REGISTRAR MAY 12 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Knapp | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

5014

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | c. LENGTH OF STAY IN 1b 11 DAYS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES., | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First LEREOY Middle A Last JEWELL | | 4. DATE OF DEATH Month MAY Day 5 Year 1959 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH SEPT. 25, 1900 |
| 9. AGE (In years last birthday) 58 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stenographic Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY Railroad | |
| 11. BIRTHPLACE (State or foreign country) PIEDMONT, W.VA. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME WILLIAM H. JEWELL | | 14. MOTHER'S MAIDEN NAME ETHEL CONRAD | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 705-05-4659 | |
| 17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure - Acute Congestive 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General Pericarditis DUE TO (c) Carcinoma Tongue Floor Mouth PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Feb 7 , 1959, to May 5 , 1959, that I last saw the deceased alive on May 5 , 1959, and that death occurred at 7:30 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7 Washington St Cumberland Md. DATE SIGNED ACTUAL SIGNATURE Leslie E. Daugherty M.D. PHYSICIAN'S NAME (Type) LESLIE E. DAUGHERTY | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5-8-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park | | 22d. LOCATION (City, town, or county) (State) Cumberland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli ADDRESS Cumberland, Md. | | 24a. REC'D BY REGISTRAR DATE MAY 11 '59 | |
| 24b. REGISTRAR'S SIGNATURE Arthur L. Hines | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

2010

ALLIANCE

INSTRUMENT

CONSTRUCTION

11-10-10

11-10-10

GENERAL & SPECIAL

LEON

SEPT. 2, 1920

WHITE

PIEDMONT, N.C.

STONE, CORNELL

WILLIAM H. BENTLEY

CENTRAL HOSPITAL, CLEVELAND, OHIO

1921, 11-10-10

CERTIFICATE OF DEATH

Reg. Dist. No.

05015

| | | | |
|--|---------------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cumberland | | c. LENGTH OF STAY IN 1b X Rural Cumberland | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mexico Farms | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Blanche Middle Pearl Last Johnson | | 4. DATE OF DEATH Month May Day 12 Year 19 59 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 17, 1891 |
| 9. AGE (In years last birthday) 67 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (State or foreign country) Fulton Co. Pa. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Andrew Barney | | 14. MOTHER'S MAIDEN NAME Sarah Beatty | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No. | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Mr. J.J. Johnson- Cumberland, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma - Ovarian DUE TO 1750 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Dietetic Mellitus | | | |
| INTERVAL BETWEEN ONSET AND DEATH 6 months | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Sept , 19 58 , to May , 19 59 , that I last saw the deceased alive on May 10 , 19 59 , and that death occurred at 7:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 133 Va Ave Cumberland, Md. DATE SIGNED 5/15/59 | | | |
| ACTUAL SIGNATURE G. O. Hommelwright, MD | | M.D. 133 Va Ave | |
| PHYSICIAN'S NAME (Type) G. O. Hommelwright, MD | | Cumberland, Md | |
| 22a. BURIAL, CREMATION, or other disposal (Specify) Burial | 22b. DATE THEREOF 5-15-1959 | 22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cem. // | 22d. LOCATION (City, town, or county) (State) Cumberland, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George | | ADDRESS Cumberland, Md. | |
| 24a. REC'D BY REGISTRAR MAY 18 1959 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

CERTIFICATE OF DEATH

INVEST AND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

MONMOUTH
 COUNTY
 NEW JERSEY
 DEPT. OF HEALTH
 BALTIMORE, MD.

| | | | | | |
|---|--|---|--|---|--|
| NAME OF DECEASED [Faint text, possibly "John Doe"] | | SEX [Faint text, possibly "Male"] | | AGE [Faint text, possibly "45"] | |
| DATE OF BIRTH [Faint text, possibly "Jan 1, 1920"] | | PLACE OF BIRTH [Faint text, possibly "New York City"] | | OCCUPATION [Faint text, possibly "Teacher"] | |
| DATE OF DEATH [Faint text, possibly "Dec 15, 1965"] | | PLACE OF DEATH [Faint text, possibly "Home"] | | CAUSE OF DEATH [Faint text, possibly "Heart Disease"] | |
| TIME OF DEATH [Faint text, possibly "10:30 AM"] | | MANNER OF DEATH [Faint text, possibly "Natural"] | | SIGNATURE OF PHYSICIAN [Faint text, possibly "Dr. J. Smith"] | |
| SIGNATURE OF REGISTRAR [Faint text, possibly "John Doe"] | | SIGNATURE OF WITNESS [Faint text, possibly "Jane Doe"] | | SIGNATURE OF DECEASED [Faint text, possibly "John Doe"] | |

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Allegany 5016 MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE W. Va. b. COUNTY Mineral | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgeley, 85x-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hosp. | | d. STREET ADDRESS Knobley, Hill | |
| 3. NAME OF DECEASED (Type or print) First Reason Middle James Last Johnson | | 4. DATE OF DEATH Month May Day 4 Year 19 59 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 2, 1881 |
| 9. AGE (In years last birthday) 78 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engine watcher | | 10b. KIND OF BUSINESS OR INDUSTRY W.Md.Rwy. | |
| 11. BIRTHPLACE (State or foreign country) Hendricks, W. Va. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME James G. Foland | | 14. MOTHER'S MAIDEN NAME Mary Jane Johnson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No, | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mr. J. Milton Johnson | | Address Cumberland, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Diabetes Mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus | | | INTERVAL BETWEEN ONSET AND DEATH hours years |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from August , 19 56 , to May , 19 59 , that I last saw the deceased alive on May 2, 19 59 , and that death occurred at 11:02 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE G. Overton Himmelwright M.D. | | ADDRESS (Street, city or town, state) 133 Virginia Ave., DATE SIGNED | |
| PHYSICIAN'S NAME (Type) G. Overton Himmelwright M.D. | | Cumberland, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 5/7/59 | 22c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cemetery | 22d. LOCATION (City, town, or county) (State) Fort Ashby, W. Va. |
| 23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George | | 24a. REC'D BY REGISTRAR MAY 7 '59 | |
| ADDRESS Cumberland, Md. | | 24b. REGISTRAR'S SIGNATURE Arthur S. Hines | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05017

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | | | |
|--|-------------------------------|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Allegany</u> 5017 MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland Md.</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Brooks Hotel, Balto Ave.</u> | | | d. STREET ADDRESS <u>Brooks Hotel Balto. Ave.</u> | | |
| 3. NAME OF DECEASED (Type or print) <u>Charles</u> | | | 4. DATE OF DEATH <u>May 27</u> 19 <u>59</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7/15/82</u> | | 9. AGE (In years last birthday) <u>76</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Border Shift</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Peter Kelly</u> | | | 14. MOTHER'S MAIDEN NAME <u>Ann Brogan</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT <u>Medical Examiner Office</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>CORONARY OCCLUSION</u> DUE TO (b) <u>Coronary Sclerosis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <u>Benedict Skitarelic</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) <u>Benedict Skitarelic MD</u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | <u>May 27, 1959.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5/30/59</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Michaels Cem.</u> | |
| | | | | 22d. LOCATION (City, town, or county) <u>Frostburg Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Steinberg</u> | | ADDRESS <u>Cumt Md</u> | | 24a. REC'D BY REGISTRAR <u>—</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

05017

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

100 STATE
HEALTH DEPT

2017

1

1. I certify that I am a duly qualified medical examiner and that I have examined the body of the deceased and that the cause of death is as stated on this certificate.

2. I certify that the deceased was not a victim of homicide, suicide, or any other crime, and that the death was not the result of any criminal act.

3. I certify that the deceased was not a victim of any other crime, and that the death was not the result of any criminal act.

4. I certify that the deceased was not a victim of any other crime, and that the death was not the result of any criminal act.

5. I certify that the deceased was not a victim of any other crime, and that the death was not the result of any criminal act.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5058 CERTIFICATE OF DEATH

Reg. Dist. No. 05018

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTERNPORT | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTERNPORT | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 300 MARYLAND AVE | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) LORETTA CATHERINE KELLY | | 4. DATE OF DEATH MAY 21, 1959 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 14, 1899 |
| 9. AGE (In years last birthday) 59 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK | | 10b. KIND OF BUSINESS OR INDUSTRY SHOE STORE | |
| 11. BIRTHPLACE (State or foreign country) ELKGARDEN W.VA. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JOHN J KELLY | | 14. MOTHER'S MAIDEN NAME CATHERINE ANN GARRITY | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 232-01-1284 | |
| 17. INFORMANT MISS GENEVIEVE KELLY, WESTERNPORT, MD. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Embolus 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Has been taking X-ray Therapy for Carcinoma of Breast for one month | | INTERVAL BETWEEN ONSET AND DEATH 15 Minutes | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 21, 1959 , to May 21, 1959 , that I last saw the deceased dead on May 21, 1959 , and that death occurred at 5:20 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Paul R. Wilson M.D. | | ADDRESS (Street, city or town, state) ASHFIELD ST, PIEDMONT, W.VA DATE SIGNED 5/21/59 | |
| PHYSICIAN'S NAME (Type) P. R. Wilson, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 5/23/59 | 22c. NAME OF CEMETERY OR CREMATORY St. PETERS CEMETERY | 22d. LOCATION (City, town, or county) (State) WESTERNPORT, MD. |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. F. Fredlock Jr ADDRESS PIEDMONT, WVA. | | 24a. REC'D BY REGISTRAR MAY 25 '59 24b. REGISTRAR'S SIGNATURE Arthur L. Hume | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05019

5059

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Allegany | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport | | c. LENGTH OF STAY IN 1b 52 yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 104 Oak View Drive | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) George Washington Kidwell | | 4. DATE OF DEATH Month May Day 13 Year 1959 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 22, 1878 |
| 9. AGE (In years last birthday) 81 yrs. | | 10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner | | 12. KIND OF BUSINESS OR INDUSTRY Coal Miner | |
| 13. FATHER'S NAME John Kidwell | | 14. MOTHER'S MAIDEN NAME Julia True | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. INFORMANT Mrs. Arthur O. Haver Address Westernport, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis and Hypertension DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 9 hours 5 Years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. Month 19 Day 13 Year 1959 | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 12, 1959 to May 13, 1959 , that I last saw the deceased alive on May 12, 1959 , and that death occurred at 6:03 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Paul R. Wilson | | DATE SIGNED May 13, 1959 | |
| PHYSICIAN'S NAME (Type) Paul R. Wilson M.D. | | M.D. Washfield St. Piedmont, W. Va. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF May 15, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY Philos Cem. | | 22d. LOCATION (City, town, or county) (State) Westernport, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE E. L. Boal | | ADDRESS Westernport, Md. | |
| 24a. REC'D BY REGISTRAR DATE MAY 14 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Haver | |

VS A15 (4)
LSM 9/58

02013

CERTIFICATE OF DEATH

5059



MADE IN GERMANY



[Faint, mostly illegible text from the reverse side of the document, including what appears to be a signature and various fields.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05020

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|----------------------------------|---|--|---|---|---|--------------------------------|
| 1. PLACE OF DEATH a. COUNTY Allegany 5018 MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | c. LENGTH OF STAY IN 1b 26yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 505 Eichner Avenue | | | | d. STREET ADDRESS 505 Eichner Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Joseph Middle Leo Last Knepp | | | | 4. DATE OF DEATH Month May Day 30 Year 19 59 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept 15, 1915 | | 9. AGE (In years last birthday) 43 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Keeper | | 10b. KIND OF BUSINESS OR INDUSTRY Artificial silk | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Henry Knepp | | | | 14. MOTHER'S MAIDEN NAME Sarah Finzel | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 214-07-5584 | | 17. INFORMANT Address Mrs. Pauline Knepp Cumberland, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, left 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary occlusion, left DUE TO (c) Coronary sclerosis | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2-3 wks. 2-3 wks. ----- | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiac hypertrophy | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Benedict Skitarelic | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 30, 1959 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/2/59 | | 22c. NAME OF CEMETERY OR CREMATORY Grantsville Cemetery | | 22d. LOCATION (City, town, or county) (State) Grantsville, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox ADDRESS Cumberland, Maryland | | | | 24a. REC'D BY REGISTRAR DATE JUN 2 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Hines | |

5060

CERTIFICATE OF DEATH

05021

Reg. Dist. No.

| | | | |
|--|---------------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg c. LENGTH OF STAY IN 1b 10 Wks. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Minor's Hospital | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vale Summit d. STREET ADDRESS R. D. No 1, Frostburg, Md. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Verna LaVelle | | 4. DATE OF DEATH Month 5 Day 20 Year 1959 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12-2-1898 |
| 9. AGE (In years last birthday) 60 yrs. | | 10. IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (State or foreign country) Vale Summit | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Thomas Giles | | 14. MOTHER'S MAIDEN NAME Lillie Norrington | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Mrs. Mabel Riley, Sister, Mt. Savage, Md | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes | | INTERVAL BETWEEN ONSET AND DEATH 2 weeks Several years | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Mar 3, 1959 , to May 20, 1959 , that I last saw the deceased alive on May 20, 1959 , and that death occurred at 3:20 P. M. , from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) DATE SIGNED | |
| ACTUAL SIGNATURE W. M. Lane M.D. | | Frostburg May 21 1959 | |
| PHYSICIAN'S NAME (Type) W. M. Lane M.D. | | mt | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 5-23-1959 | 22c. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery | 22d. LOCATION (City, town, or county) (State) Frostburg Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Pearl H. Mattingly | | ADDRESS Frostburg, Md. | |
| 24a. REC'D BY REGISTRAR MAY 25 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur E. Evans | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100-1

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

100-1

DATE OF DEATH

DECEASED

DATE OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No.

5061

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|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Finzel 11X-2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Lawrence Middle L. Last Layton | | 4. DATE OF DEATH Month May Day 15th Year 1959 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 11th, 1905 |
| 9. AGE (In years last birthday) 53 yrs. | | 10. IF UNDER 1 YEAR Months 53 Days 53 Hours 53 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor | | 10b. KIND OF BUSINESS OR INDUSTRY High School | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Howard Layton | | 14. MOTHER'S MAIDEN NAME Mary McKenzie | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. 201-01-8711 | |
| 17. INFORMANT Mrs. Clara E. Layton | | Address Finzel Rd., Frostburg, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pancreatitis 585X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cholecystitis DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 3 days 2 weeks | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 1 , 19 59 , to May 15 , 19 59 , that I last saw the deceased alive on May 15 , 19 59 , and that death occurred at 7:35 A.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE W. O. McLane | | ADDRESS (Street, city or town, state) 167 E. Main Street, May 15 | |
| PHYSICIAN'S NAME (Type) W. O. McLane, | | M.D. Frostburg, Md., 1959 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5-18-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY Layton Cemetery | | 22d. LOCATION (City, town, or county) (State) Garrett County, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md. | | ADDRESS 24a. REC'D BY REGISTRAR DATE MAY 19 59 | |
| 24b. REGISTRAR'S SIGNATURE Arthur E. Kraus | | | |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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CERTIFICATE OF DEATH

1961

Germany

Germany

Germany

14 days

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14 days

1961

1961

1961

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1961

USA

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USA

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USA

1961-07-27

1961-07-27

1961-07-27

1961-07-27

1961-07-27

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05023

5019

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|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u> | | | | c. LENGTH OF STAY IN lb <u>15 Days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>RICHARD</u> <u>S.</u> <u>LEYH</u> | | | | 4. DATE OF DEATH Month Day Year <u>5</u> <u>30</u> <u>19 59</u> | | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>1-12-17</u> | |
| 9. AGE (In years lost birthday) <u>12</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND, Cumberland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13. FATHER'S NAME <u>WILLIAM LEYH</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Geraldine</u> <u>ADDRESS (WILLIAMS)</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | INFORMANT <u>CHART</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>164X</u> IMMEDIATE CAUSE (a) <u>Hemangio endothelioma anterior</u> DUE TO (b) <u>mediastinum</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE <u>Paul D. Paul</u> M.D. | | | | PHYSICIAN'S NAME (Type) <u>E.M. PAUL M.D.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6-1-59</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u> | | 22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u> | | | | ADDRESS <u>Cumberland, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>JUN 3 '59</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u> | | | |

15083

CERTIFICATE OF DEATH

5012

10



1



CERTIFICATE OF DEATH

Reg. Dist. No.

05024

5020

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|--|-------------------------------|---|--------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | | | c. LENGTH OF STAY IN lb 4 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, OR INSTITUTION) WARWICK & MEMORIAL HOSPITAL | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First LESTER Middle RAY Last LILLER | | | | 4. DATE OF DEATH Month MAY Day 20 Year 1959 | | | |
| 5. SEX MALE MMXXE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH AUGUST 13 | 9. AGE (In years last birthday) yrs. 54 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Spotter | | 10b. KIND OF BUSINESS OR INDUSTRY Dry Cleaning | | 11. BIRTHPLACE (State or foreign country) WEST VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME CHARLES LILLER | | | | 14. MOTHER'S MAIDEN NAME LEAH MY DAVIS SAVILLA KING | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 236 42 7150 | | INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MARYLAND | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Critter - Pushter Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Secondary Coronary Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 days 3 years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Sept 1956 to May 1959 that I last saw the deceased alive on May 20, 1959 , and that death occurred at 6:00P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 133 Virginia Ave Elk Garden, W. Va. DATE SIGNED 5/20/59 | | | | | | | |
| ACTUAL SIGNATURE Dr. Overton Himmelwright | | PHYSICIAN'S NAME (Type) DR. OVERTON HIMMELWRIGHT | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF May 23, 1959 | | 22c. NAME OF CEMETERY OR CREMATORY Nethkin Hill Cemetery | | 22d. LOCATION (City, town, or county) (State) Elk Garden, W. Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE William H. Right ADDRESS Cumberland, Md. | | | | 24a. REC'D BY REGISTRAR MAY 25 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05051

CERTIFICATE OF DEATH

1900

ALLIANCE

HAYWARD

ALLIANCE

17 PROJECT COUNTY

FEDERAL HOSPITAL

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1900

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U. S. A.

WEST VIRGINIA

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CERTIFICATE OF DEATH

Reg. Dist. No.

5021

| | | | |
|--|---------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH ALLEGANY COUNTY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) MARYLAND STATE b. COUNTY GARRETT | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, | | c. LENGTH OF STAY IN 1b 10 DAYS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, WARWICK & MEMORIAL AVE. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ ACCIDENT, MD. 11X-2 | |
| d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First MARY Middle A. Last MARGRAFF | | 4. DATE OF DEATH Month MAY Day 11 Year 1959 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH DEC. 29, 1884 |
| 9. AGE (In years last birthday) 74 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY own home | |
| 11. BIRTHPLACE (State or foreign country) ACCIDENT, MD. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME FRANTZ CONRAD | | 14. MOTHER'S MAIDEN NAME ELIZABETH LEINSETTER | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592x DUE TO Subacute pyelonephritis with terminal uraemia 2 months (b) Chronic nephritis, arteriosclerosis (c) Hypertension, arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH ? ? | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1 May, 1959, to 11 May, 1959, that I lost s/he the deceased alive on 10 May, 1959, and that death occurred at 2:15 AM, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE W. Alfred Van Ormer M.D. | | ADDRESS (Street, city or town, state) DATE SIGNED 11 May 59 | |
| PHYSICIAN'S NAME (Type) DR. VAN ORMER | | Cumberland, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/13/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY English Lutheran | | 22d. LOCATION (City, town, or county) (State) Accident, Garrett Co., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Don J. Newman | | ADDRESS Grantsville, Md. | |
| 24a. REC'D BY REGISTRAR DATE MAY 14 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas | |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

112025

CERTIFICATE OF DEATH

5031



CURRENT

PREVIOUS

ALLIED-WY

ACCIDENT, 10

10 DAYS

ON DEATH

GENERAL HOSPITAL, MARION STREET, WY

11

WY

ACCIDENT

BY

WHITE

ACCIDENT, 10

GENERAL HOSPITAL

GENERAL HOSPITAL, MARION STREET, WY

DR. J. W. GIBBS

CERTIFICATE OF DEATH

Reg. Dist. No.

05026

5022

| | | | |
|--|-------------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | c. LENGTH OF STAY IN 1b 4 DAYS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL AND WARWICK AVENUES | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First OTHO Middle P Last MATTHEWS | | 4. DATE OF DEATH Month MAY Day 15 Year 19 59 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH AUGUST 24, 1887 |
| 9. AGE (In years last birthday) 71 yrs. | | 10. UNDER 1 YEAR Months 71 Days 71 Hours 71 Min. 71 | 11. UNDER 24 HRS. Months 71 Days 71 Hours 71 Min. 71 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager | | 10b. KIND OF BUSINESS OR INDUSTRY Hotel | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME WILLIAM MATTHEWS | | 14. MOTHER'S MAIDEN NAME MARTHA Moreland | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 214-05-9253 | |
| 17. INFORMANT MEMORIAL HOSPITAL | | Address CUMBERLAND, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonitis, left lung DUE TO (c) Hypertensive and Arteriosclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH 1 hour 6 days years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus, uncontrolled; Parkinsonism 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 10, 1959 , to May 15th, 1959 , that I last saw the deceased alive on May 15th, 1959 , and that death occurred at 9:25 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Algonquin Hotel DATE SIGNED ACTUAL SIGNATURE Wyand F. Doerner Jr M.D. Algonquin Hotel PHYSICIAN'S NAME (Type) DR. WYAND F. DOERNER JR Cumberland, Maryland. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 5/18/59 | 22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park | 22d. LOCATION (City, town, or county) (State) Cumberland Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox | | 24a. REC'D BY REGISTRAR DATE MAY 19 '59 | |
| ADDRESS Cumberland Maryland | | 24b. REGISTRAR'S SIGNATURE Arthur L. Hume | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05028

05028



CERTIFICATE OF DEATH

Reg. Dist. No.

5023

| | | | | | | | |
|---|---------------------------------|--|---------------------------------|---|-----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 CUMBERLAND</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>THOMAS N. MATTHEWS</u> | | | | 4. DATE OF DEATH Month Day Year <u>MAY 24 1959</u> | | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>COLORED</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3/10/79</u> | 9. AGE (In years last birthday) <u>80</u> yrs. | IF UNDER 1 YEAR Months Days Hours | | IF UNDER 24 HRS. Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bellhop.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>H. Cumb. Hotel</u> | | 11. BIRTHPLACE (State or foreign country) <u>Cumberland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. H.</u> | |
| 13. FATHER'S NAME <u>Thomas Mathew</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Harriet (Unknown)</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> | | 16. SOCIAL SECURITY NO. <u>220-03-7962</u> | | INFORMANT Address <u>Miss Otelia Kent. Cumb. Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renovated arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>years</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>May 14</u> , 19 <u>59</u> , to <u>May 24</u> , 19 <u>59</u> , and that death occurred at <u>MD</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>B. M. Schindler</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>43 Bruce St. Cumberland Md 5-4559</u> | | | |
| PHYSICIAN'S NAME (Type) <u>BLANE M. SCHINDLER M.D.</u> | | | | DATE SIGNED | | | |
| 22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5/27/59</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Pace Hill Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u> ADDRESS <u>Cumb. Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>JUN 1 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05083

STATE OF TEXAS

05083

NOV 11 1904

[Faint, mostly illegible text, likely a legal document or record, possibly a deed or contract. The text is mirrored across the page, suggesting a bleed-through from the reverse side.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05028

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | | | |
|--|---|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Allegany 5624 MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | c. LENGTH OF STAY IN 1b 60yrs | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 02 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 308 Arch Street | | | d. STREET ADDRESS 308 Arch Street | | |
| 3. NAME OF DECEASED (Type or print) Joseph Michael Mc Clain | | | 4. DATE OF DEATH Month May Day 21 Year 1959 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 28, 1896 | | 9. AGE (In years last birthday) 62 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Burner-retired | | 10b. KIND OF BUSINESS OR INDUSTRY Railroad | | 11. BIRTHPLACE (State or foreign country) Piedmont, W. Va. | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Martin Mc Clain | | | 14. MOTHER'S MAIDEN NAME Josephine Rowan | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT Address Mrs. Ernest Weisenmiller, Cumberland Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Sclerosis DUE TO (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH sudden ---- |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE Benedict Skitarelic | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 22, 1959 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 5-25-59 | 22c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery | | 22d. LOCATION (City, town, or county) (State) Cumberland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md. | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE MAY 25 '59 | 24b. REGISTRAR'S SIGNATURE Arthur S. Thaw |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Book of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR SALE
HEALTHY DEER

CERTIFICATE OF DEATH

Reg. Dist. No.

05029

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY ALLEGANY 5025 MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, | | c. LENGTH OF STAY IN 1b 39 DAYS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL AND WARWICK AVENUES | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First MICHAEL Middle F Last MC GEE | | 4. DATE OF DEATH Month MAY Day 28 Year 19 59 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MARCH 30, 1883 |
| 9. AGE (In years lost birthday) yrs. 76 | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bottle House, Brewery | | 10b. KIND OF BUSINESS OR INDUSTRY MC KEEPORT, PA | |
| 11. BIRTHPLACE (State or foreign country) U. S. A. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME PETER MC GEE | | 14. MOTHER'S MAIDEN NAME CATHERINE HOOP | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214-05-5016 | |
| 17. INFORMANT MEMORIAL HOSPITAL | | Address CUMBERLAND, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X DUE TO Chemia Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Chronic Glomerulonephritis (c) Chronic Glomerulonephritis | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 mte | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 28 April, 1959 , to 28 May, 1959 , that I last saw the deceased alive on 28 May, 1959 , and that death occurred at 2:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 12240 Centre St, Cumberland Md. DATE SIGNED 31 May 59 | | | |
| ACTUAL SIGNATURE James E. Stegmair M.D. | | DATE SIGNED 31 May 59 | |
| PHYSICIAN'S NAME (Type) DR. JAMES STEGMAIER | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 6-I-59 | 22c. NAME OF CEMETERY OR CREMATORY Zion Memorial Cem. | 22d. LOCATION (City, town, or county) (State) Cumberland, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli | | 24a. REC'D BY REGISTRAR DATE JUN 2 '59 | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

CERTIFICATE OF DEATH

DECEASED

NAME

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

1

2

3

4

5

6

DATE OF BURIAL

PLACE OF BURIAL

DATE OF INTERMENT

DATE OF INTERMENT

DATE OF INTERMENT

DATE OF INTERMENT

DATE OF INTERMENT

DATE OF INTERMENT

DATE OF INTERMENT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05030

Reg. Dist. No.

5026

| | | | |
|--|------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | c. LENGTH OF STAY IN 1b 150 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Pearl Middle Kelly Last McGee | | 4. DATE OF DEATH Month May Day 23 Year 19 59 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct 3, 1901 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own home | 9. AGE (In years last birthday) 57 yrs. |
| 11. BIRTHPLACE (State or foreign country) Collinwood, Tenn. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William Dixon | | 14. MOTHER'S MAIDEN NAME Lillie Morgan | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Mrs. Thomas Harvey, Box 113, Mt. Savage, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, generalized 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of uterus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 8-12 mo 1 1/2 yrs. | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec 24, 1958 , to May 23, 1959 , that I last saw the deceased alive on May 23, 1959 , and that death occurred at 9:04 M., from the causes and on the date stated above ADDRESS (Street, city or town, state) 115 So. Centre St DATE SIGNED 5/23/59 ACTUAL SIGNATURE Dr. A. J. Mirkkin M.D. Cumberland, Md PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF May 26, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY Green River Cemetery | | 22d. LOCATION (City, town, or county) (State) Waynesboro, Tenn. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Md. | | 24a. REC'D BY REGISTRAR DATE MAY 27 '59 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Hanna | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4262

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1.4 FilmG242 5-18-59 et

5062

CERTIFICATE OF DEATH

05031

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport | | | | c. LENGTH OF STAY IN 1b 1 Hr. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 60 Main "Business Establish." | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Addis Milton Michael | | | | 4. DATE OF DEATH Month Day Year May 9, 19 59 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH April 27, 1892 | |
| 9. AGE (In years last birthday) 67 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner | | 10b. KIND OF BUSINESS OR INDUSTRY Coal Mine | | 11. BIRTHPLACE (State or foreign country) W.Va. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Lewis Michael | | | | 14. MOTHER'S MAIDEN NAME Sarah Taylor | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 192-09-6055 | | INFORMANT Address Katherine L Upperman-Bloomington, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) U | | | | | | INTERVAL BETWEEN ONSET AND DEATH minutes | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) Westernport Allegany Md. | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 4 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED William W. Lesh M.D. 60 Main St. Westernport, Md. 5-11-59 | | | | | | | |
| ACTUAL SIGNATURE William W. Lesh | | PHYSICIAN'S NAME (Type) William W. Lesh-M.D. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/12/59 | | 22c. NAME OF CEMETERY OR CREMATORY Bloomington | | 22d. LOCATION (City, town, or county) (State) Bloomington, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE E. Boal | | ADDRESS Westernport, Md. | | 24a. REC'D BY REGISTRAR DATE MAY 12 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

180031

CERTIFICATE OF DEATH

1943



1



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05032

Reg. Dist. No.

| | | | |
|---|-------------------------------|--|---------------------------------|
| 1. PLACE OF DEATH o. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat | | d. STREET ADDRESS 930 Glenwood Street | |
| 3. NAME OF DECEASED (Type or print) First Amy Middle ---- Last Miller | | 4. DATE OF DEATH Month May Day 26 Year 19 59 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2/28/80 |
| 9. AGE (In years last birthday) 79 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own home | |
| 11. BIRTHPLACE (State or foreign country) Silver Mills, Penna. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME George W. Barnes | | 14. MOTHER'S MAIDEN NAME Sarah Jane Diehl | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No, (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 213-24-672 | |
| 17. INFORMANT Mrs. Cora Appold | | Address Cumb. Md. 604 Fairview Ave., | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422 Chronic Myocardial Degeneration DUE TO 592x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) 450 General Arteriosclerosis DUE TO 592 Chronic Nephritis (c) 304 Severe psychosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ? INTERVAL BETWEEN ONSET AND DEATH ? | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Mar. 16, 1957 to May 26, 1959 , that I last saw the deceased alive on May 25th, 1959 , and that death occurred at AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE James E. McLean | | ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 5/26/59 | |
| PHYSICIAN'S NAME (Type) James E. McLean, M.D. | | 49 Greene St., Cumberland, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/29/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery | | 22d. LOCATION (City, town, or county) (State) Artemas, Penna. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George | | ADDRESS Cumberland, Md. | |
| 24a. REC'D BY REGISTRAR JUN 1 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Frank | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2021

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|-------------------|--|---------------|--|---------------------|--|---------------------|--|-------------------------|--|-------------------------|--|------------------------|--|------------------------|--|-------------------------|--|-------------------------|--|--------------------------|--|--------------------------|--|-------------------|--|-------------------|--|-------------------|--|-------------------|--|-----------------|--|-----------------|--|-------------------|--|-------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | | DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | OCCUPATION | | EDUCATION | | RELIGION | | MARRIAGE | | SINGLE | | MARRIED | | WIDOWED | | DIVORCED | | SEPARATED | | OTHER | |
| JAMES H. SMITH | | 45 | | M | | W | | 1976 | | BALTIMORE, MD | | 1976 | | BALTIMORE, MD | | HEART DISEASE | | NATURAL | | CLERK | | HIGH SCHOOL | | METHODIST | | MARRIED | | MARRIED | | MARRIED | | MARRIED | | MARRIED | | MARRIED | | | |
| FATHER'S NAME | | MOTHER'S NAME | | FATHER'S OCCUPATION | | MOTHER'S OCCUPATION | | FATHER'S PLACE OF BIRTH | | MOTHER'S PLACE OF BIRTH | | FATHER'S DATE OF BIRTH | | MOTHER'S DATE OF BIRTH | | FATHER'S CAUSE OF DEATH | | MOTHER'S CAUSE OF DEATH | | FATHER'S MANNER OF DEATH | | MOTHER'S MANNER OF DEATH | | FATHER'S RELIGION | | MOTHER'S RELIGION | | FATHER'S MARRIAGE | | MOTHER'S MARRIAGE | | FATHER'S SINGLE | | MOTHER'S SINGLE | | FATHER'S DIVORCED | | MOTHER'S DIVORCED | |
| JOHN A. SMITH | | MARY B. SMITH | | CLERK | | HOUSEWIFE | | BALTIMORE, MD | | BALTIMORE, MD | | 1931 | | 1938 | | HEART DISEASE | | HEART DISEASE | | NATURAL | | NATURAL | | METHODIST | | METHODIST | | MARRIED | | MARRIED | | MARRIED | | MARRIED | | MARRIED | | MARRIED | |
| DATE OF INTERVIEW | | INTERVIEWER | | DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | OCCUPATION | | EDUCATION | | RELIGION | | MARRIAGE | | SINGLE | | MARRIED | | WIDOWED | | DIVORCED | | SEPARATED | | OTHER | | DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | | | |
| 1976 | | J. H. SMITH | | 1976 | | BALTIMORE, MD | | HEART DISEASE | | NATURAL | | CLERK | | HIGH SCHOOL | | METHODIST | | MARRIED | | MARRIED | | MARRIED | | MARRIED | | MARRIED | | MARRIED | | MARRIED | | 1976 | | BALTIMORE, MD | | HEART DISEASE | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5063

CERTIFICATE OF DEATH

05033

Reg. Dist. No.

| | | | |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg | | c. LENGTH OF STAY IN lb 6 yrs. | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frost burg | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital | | d. STREET ADDRESS 73 Spring St. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Benjamin First Rolland Middle Miller Last | | 4. DATE OF DEATH May Month 4 Day 19 59 Year | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 20, 1878 |
| 9. AGE (In years last birthday) 81 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farming | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Samuel J. Miller | | 14. MOTHER'S MAIDEN NAME Ellen Wilt | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. INFORMANT Address Albert Miller --- 73 Spring St. Frostburg, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Arterio Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH 1 1/2 to several years | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 3, 1959 to May 4, 1959 that I last saw the deceased alive on May 3, 1959 and that death occurred at 8:45 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE W O M Lane M D | | ADDRESS (Street, city or town, state) Frostburg Maryland DATE SIGNED May 6 1959 | |
| PHYSICIAN'S NAME (Type) W O M Lane M D | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/6/1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY Miller Cem. | | 22d. LOCATION (City, town, or county) (State) Allegany Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE E. S. Boal ADDRESS Westernport, Maryland | | 24a. REC'D BY REGISTRAR DATE MAY 14 '59 24b. REGISTRAR'S SIGNATURE Arthur E. House | |

05068

CERTIFICATE OF DEATH

05068

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

Form with multiple sections for recording death information, including fields for name, date, time, place, and cause of death. The form is heavily faded and contains significant bleed-through from the reverse side.

CERTIFICATE OF DEATH

Reg. Dist. No.

05034

5028

| | | | |
|---|------------------------------------|---|--|
| 1. PLACE OF DEATH o. COUNTY 8 ALLEGANY M | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | c. LENGTH OF STAY IN lb 22 DAYS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First ANNA Middle C. Last MITCHELL | | 4. DATE OF DEATH Month MAY Day 31 Year 1959 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JANUARY 20, |
| 9. AGE (In years lost birthday) 69 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper | | 10b. KIND OF BUSINESS OR INDUSTRY at Home | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME John Rompf | | 14. MOTHER'S MAIDEN NAME MARY KROUSE | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Mrs. Helen Brown Cumberland, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Degeneration (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 5/18 , 19 59 , to 5/31 , 19 59 , that I last saw the deceased alive on 5/30 , 19 59 , and that death occurred at 5:45 AM from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Leo H. Ley | | DATE SIGNED 6/1/59 | |
| PHYSICIAN'S NAME (Type) DR. LEO H. LEY | | ADDRESS (Street, city or town, state) Cumberland, Md | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 6/2/59 | 22c. NAME OF CEMETERY OR CREMATORY Rest Lawn Memorial Park | 22d. LOCATION (City, town, or county) (State) Cumberland, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox | | 24a. REC'D BY REGISTRAR JUN 3 '59 | |
| ADDRESS Cumberland, Maryland | | 24b. REGISTRAR'S SIGNATURE Arthur L. Hume | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

ALLIED

MARYLAND

2 JUL 1952

CO. 100

25 JUL 52

CINCINNATI

102 E. YETTS STREET

WEST VIRGINIA

HEMLOCK

21 JUL 52

WVA

MITCHELL

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WVA

25 JUL 52

WEST VIRGINIA

WHITE

EDMUND

MARYLAND

25 JUL 52

WEST VIRGINIA

MARY K. ROUSE

John Ford

I

DR. LEO H. LAY

West Virginia

6/25

1952

West Virginia

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West Virginia

West Virginia

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05035

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|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Allegany 5029 MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | c. LENGTH OF STAY IN 1b 10 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital | | | | d. STREET ADDRESS 131 N. Centre St. | | | |
| 3. NAME OF DECEASED (Type or print) Pearl | | | | 4. DATE OF DEATH May 6 1959 | | | |
| 5. SEX Female | | 6. COLOR OR RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Nov. 28, 1891 | |
| | | | | 9. AGE (In years last birthday) 67 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY West Virginia | | 11. BIRTHPLACE (State or foreign country) USA | |
| 13. FATHER'S NAME Alexander Eversole | | | | 14. MOTHER'S MAIDEN NAME Mary Jane Compton | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 214-14-7682 | | 17. INFORMANT Daughter 131 N. Centre St. Cumb. Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Contusion of Brain 904.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Injury sustained in fall DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 10 days 10 days | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell while going home from work | | | | | |
| 20c. TIME OF INJURY Month, Day, Year 12:30 April 28 '59 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Centre & Polk St. Cumberland, Alleg. Maryland | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Benedict Skitarelic | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 6, 1959 | | | |
| 22a. BURIAL, CREMATION, EX-OVATION (Specify) Burial | | 22b. DATE THEREOF 5/10/59 | | 22c. NAME OF CEMETERY OR CREMATORY Sunset Mem. Pk. | | 22d. LOCATION (City, town, or county) (State) Cumberland Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. | | | | ADDRESS Cumb. Md. | | 24a. REC'D BY REGISTRAR MAY 11 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur L. Harris | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

05036

5030

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|--|----------------------------------|---|---|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | | | c. LENGTH OF STAY IN 1b 21 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES., | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First WALTER Middle E Last MUELLER | | | | 4. DATE OF DEATH Month MAY Day 4 Year 1959 | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAY 31 | 9. AGE (In years last birthday) yrs. 70 | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) LaCrosse, Wisconsin | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME CHARLES MUELLER | | | | 14. MOTHER'S MAIDEN NAME MARIE UNGEWICKEL | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | | 16. SOCIAL SECURITY NO. | | INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4.13.59 | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 4.13.1959 to 5.4.1959 at last saw the deceased alive on 5.31.1959 , and that death occurred at 8:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED 5/4/59 | | | | | | | |
| ACTUAL SIGNATURE W.F. Williams | | | PHYSICIAN'S NAME (Type) W.F. WILLIAMS SULPHUR SPRINGS | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF 5/7/59 | | 22c. NAME OF CEMETERY OR CREMATORY CUMBERLAND | | 22d. LOCATION (City, town, or county) (State) PAW PAW, W. VA. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Parks, E. E. Pinner | | | | 24a. REC'D BY REGISTRAR Arthur L. Pinner DATE MAY 6 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Pinner | |

4
Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

115036

CERTIFICATE OF DEATH

115036

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CERTIFICATE OF DEATH

Reg. Dist. No.

5031

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|---|----------------------------------|---|---------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | c. LENGTH OF STAY IN lb 2 DAYS | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ FORT ASHBY 85x-3 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL AND WARWICK AVENUES | | d. STREET ADDRESS | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last GEORGE GRADY MUTCH | | 4. DATE OF DEATH Month Day Year MAY 16 1959 | | | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH FEB 7 1879 | 9. AGE (In years last birthday) 80 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman Weaving Dept Celanese Corp. | | 10b. KIND OF BUSINESS OR INDUSTRY CELANESE CORP. | | 11. BIRTHPLACE (State or foreign country) PENNSYLVANIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William P. MUTCH | | 14. MOTHER'S MAIDEN NAME Katherine Heckelroth | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214-07-5896 | | INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.1 DUE TO Diseases of age Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO — (c) DUE TO — | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 yrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. — 19 | | 20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 3/22/56 , 19 to 5/14/59 , that I last saw the deceased alive on 5/14/59 , and that death occurred at 4:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED DR. R. J. WMS. 5/18/59 | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF May 19, 1959 | | 22c. NAME OF CEMETERY OR CREMATORY Marietta Cemetery | | 22d. LOCATION (City, town, or county) (State) Marietta, Penna. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, | | ADDRESS Cumberland, Md. | | 24a. REC'D BY REGISTRAR DATE MAY 19 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05032

ARMY AND NAVAL DEPARTMENT OF HEALTH - BALTIMORE 10

CENTRAL DEPT. OF HEALTH

10031

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CERTIFICATE OF DEATH

Reg. Dist. No.

05038

5032

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|---|--------------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | c. LENGTH OF STAY IN 1b 5 DAYS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES., | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First CARL Middle J. Last NILSSON | | 4. DATE OF DEATH Month MAY Day 5 Year 1959 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH OCTOBER 7 |
| 9. AGE (in years last birthday) 78 yrs. | | 10. IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min. | 11. IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist | | 10b. KIND OF BUSINESS OR INDUSTRY Celene Corp. | |
| 11. BIRTHPLACE (State or foreign country) Sweden | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME EDWARD NILSSON | | 14. MOTHER'S MAIDEN NAME Anna ? | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis 540.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Perforated Gastric Ulcer DUE TO (c) Ulcer | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Abscess Rt Lower lobe of lung; Pulmonary Emphysema | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1958, 11/11/58 to 5/5/59 , 19 59 , that I last saw the deceased alive on 5/5/59 , 19 59 , and that death occurred at 11:10 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Alfred Weisman M.D. | | DATE SIGNED 5/6/59 | |
| PHYSICIAN'S NAME (Type) S. G. WEISMAN | | Cumberland, Md | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF May 7, 1959 | 22c. NAME OF CEMETERY OR CREMATORY St. Marys Burial Park | 22d. LOCATION (City, town, or county) (State) Cumberland, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Louis Stern, Inc. Cumberland, Md | | 24a. REC'D BY REGISTRAR MAY 11 '59 | 24b. REGISTRAR'S SIGNATURE Arthur L. Hume |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

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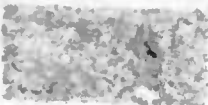
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RECEIVED AT THE OFFICE OF THE



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05039**

FOR STATE
HEALTH DEPT.

5033

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|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | c. LENGTH OF STAY IN 1b D.O.A. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital | | e. STREET ADDRESS 7 | |
| 3. NAME OF DECEASED (Type or print) First John Middle Joseph Last Nolan | | 4. DATE OF DEATH Month May Day 22nd , Year 1959 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 13th, 1897 |
| 9. AGE (In years last birthday) 62 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe fitter helper | | 10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp. | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Michael Nolan | | 14. MOTHER'S MAIDEN NAME Ellen Durkin | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes | | 16. SOCIAL SECURITY NO. W.W.1 214-07-6115 | |
| 17. INFORMANT Address Mrs. Beatrice Nolan, Mt. Savage, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary Sclerosis (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Benedict Skitarelic M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED May 22, 1959 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5-25-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery | | 22d. LOCATION (City, town, or county) (State) Mt. Savage, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md. | | 24a. REC'D BY REGISTRAR DATE MAY 23 '59 | |
| 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10000

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|-------------------------------|--|------------------------|--|
| Name of Deceased | | John | |
| Residence | | Johns Hopkins Hospital | |
| Age | | D.O.B. | |
| Sex | | Male | |
| Race | | White | |
| Marital Status | | Single | |
| Cause of Death | | Pneumonia | |
| Date of Death | | May 22, 1922 | |
| Place of Death | | Johns Hopkins Hospital | |
| Physician | | Dr. J. H. H. H. | |
| Signature of Physician | | [Signature] | |
| Signature of Medical Examiner | | [Signature] | |
| Date of Certificate | | May 22, 1922 | |
| Place of Issue | | Baltimore, Md. | |

5071 CERTIFICATE OF DEATH

05040

Reg. Dist. No.

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|--|----------------------------------|---|---|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Luke | | | | c. LENGTH OF STAY IN 1b 66 Yrs | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 297 Pratt | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Hellen Baird Oates | | | | 4. DATE OF DEATH Month May Day 19 Year 1959 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 15, 1882 | 9. AGE (In years last birthday) 76 yrs. | IF UNDER 1 YEAR Months 7 Days 18 Hours 15 Min. | IF UNDER 24 HRS. Hours 15 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Scotland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME John Jack | | | | 14. MOTHER'S MAIDEN NAME Mary Blair | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. Informant | | | |
| 17. ADDRESS Mrs. Elmer Mays— Luke, Md. | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Congestive heart failure., DUE TO (b) Generalized Arterio Sclerosis., DUE TO (c) 3mo Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3mo |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 25, 1959 , to May 19, 1959 , that I last saw the deceased alive on May 18, 1959 , and that death occurred at am M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Piedmont W Va DATE SIGNED James H. Wolverton Sr ACTUAL SIGNATURE James H. Wolverton Sr M.D. Piedmont W Va PHYSICIAN'S NAME (Type) James H. Wolverton Sr Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/21/59 | | 22c. NAME OF CEMETERY OR CREMATORY Philos | | 22d. LOCATION (City, town, or county) (State) Westernport Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE El. Boal ADDRESS Westernport, Md. | | | | 24a. REC'D BY REGISTRAR DATE MAY 21 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon portions. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

05041

5034

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| 1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | c. LENGTH OF STAY IN 1b 27 DAYS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES | | d. STREET ADDRESS 68 WEST HAMPSHIRE ST. | |
| 3. NAME OF DECEASED (Type or print) First MICHAEL Middle F. Last O'DONNELL | | 4. DATE OF DEATH Month MAY Day 1 Year 19 59. | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH AUGUST 8, 1867. |
| 9. AGE (In years last birthday) yrs. 91 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer | | 10b. KIND OF BUSINESS OR INDUSTRY Pastor R.R. Co - | |
| 11. BIRTHPLACE (State or foreign country) TERRA ALTA, W. VA. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME EDWARD O'DONNELL | | 14. MOTHER'S MAIDEN NAME MARGARET HOBAN | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line or (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Arteriosclerosis | | | INTERVAL BETWEEN ONSET AND DEATH ? |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic nephritis, Anemia - secondary | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 4-8-59 to 5-1-59 that I last saw the deceased alive on 4-30-59 and that death occurred at 10:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Howard Tolson, Md. 5-4-59 DATE SIGNED ACTUAL SIGNATURE Howard Tolson M.D. Cumberland, Md. 5-4-59 PHYSICIAN'S NAME (Type) DR. HOWARD L. TOLSON | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| Burial | 5-4-59 | St. Peters Cemetery | Westport, Md |
| 23. FUNERAL DIRECTOR'S SIGNATURE Fredlock Funeral Home Charles H. Chaney | | 24a. REC'D BY REGISTRAR DATE MAY 6 '59 | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

Arteriosclerosis

chronic nephritis, terminal - secondary

4-8-21-21-21

Howard J. ...
Cumberland ...

CERTIFICATE OF DEATH

Reg. Dist. No.

05042

5035

| | | | |
|--|------------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | c. LENGTH OF STAY IN 1b 14 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Alice Middle Ogle Last Ogle | | 4. DATE OF DEATH Month 5 Day 18 Year 1959 | |
| 5. SEX Female | 6. COLOR OR RACE Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-4-92 |
| 9. AGE (In years lost birthday) yrs. 67 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | |
| 11. BIRTHPLACE (State or foreign country) Pa. Washington | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME A. Gross | | 14. MOTHER'S MAIDEN NAME Mary Jane | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Edward P. Ogle, | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of Liver 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Alcohol DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia, 1 month | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | |
| 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that I attended the deceased from May 18, 1958 to May 18, 1959 that I last saw the deceased alive on May 18, 1959 , and that death occurred at 8:30 P.M. , from the causes and on the date stated above. | |
| ACTUAL SIGNATURE B. M. Schindler M.D. | | ADDRESS (Street, city or town, state) 43 Greene St., Cumberland, MD | |
| DATE SIGNED May 5/1959 | | PHYSICIAN'S NAME (Type) Dr. B. M. Schindler M.D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF May 22, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY Woodlawn Burial Park | | 22d. LOCATION (City, town, or county) (State) Cumberland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland | | 24a. REC'D BY REGISTRAR DATE MAY 22 '59 | |
| 24b. REGISTRAR'S SIGNATURE Arthur L. Kline | | | |

CENTRAL AVE OF DEATH

5082

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John A. Baker, Maryland, Maryland
May 22, 1922 [Social Security Card] Charles A. Maryland

5036

CERTIFICATE OF DEATH

Reg. Dist. No.

05043

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| 1. PLACE OF DEATH a. COUNTY ALEEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY Bedford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYNDMAN | |
| c. LENGTH OF STAY IN 1b 4 DAYS | | d. STREET ADDRESS R.F.D.#1 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES., | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) OSTER | | 4. DATE OF DEATH MAY 4 19 59 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JANUARY 13, 1891 |
| 9. AGE (In years last birthday) 68 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman | | 10b. KIND OF BUSINESS OR INDUSTRY B&O Railroad | |
| 11. BIRTHPLACE (State or foreign country) BEDFORD VALLEY, PENNA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME CALVIN OSTER | | 14. MOTHER'S MAIDEN NAME KATE GROWDEN | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 214-07-0601 | |
| 17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture Aneurysm of abdominal aorta 451X DUE TO Arterio-sclerotic Cardiovascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Renal disease - advanced DUE TO (c) Immediate 4 yrs ⁺ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from April 30, 1959 , to May 4, 1959 , that I last saw the deceased alive on May 4, 1959 , and that death occurred at 9:50 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE W. M. Fawcett | | ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED May 4, 1959 | |
| PHYSICIAN'S NAME (Type) WYLIE M. FAW | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF May 6, 1959 | 22c. NAME OF CEMETERY OR CREMATORY Porter Cemetery | 22d. LOCATION (City, town, or county) (State) Hyndman, Pa. RD#1 |
| 23. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Legler | | ADDRESS Hyndman, Pa. | 24a. REC'D BY REGISTRAR DATE MAY 7 '59 |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. Frank | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VS A15 (4)
ISM 9/58

05043

CERTIFICATE OF DEATH

5038

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05044

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the State Board of Health. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|---|----------------------------------|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Allegany 5037 MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | c. LENGTH OF STAY IN lb 5 minutes | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital | | | d. STREET ADDRESS 120 Averette Ave. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last James Michael Phillips | | | 4. DATE OF DEATH Month Day Year 5/ 18 19 59 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/26/76 | | 9. AGE (in years last birthday) 82 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R.R. Conductor | | 10b. KIND OF BUSINESS OR INDUSTRY Railroad | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 13. FATHER'S NAME Issac Phillips | | | 14. MOTHER'S MAIDEN NAME Mary Michaels | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 705 12 2586 | | 17. INFORMANT Mary J. Phillips Address Cumberland, Md | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Aspiration of stomach contents 541.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Bleeding duodenal ulcer (c) 3-4 hrs. DUE TO causing the underlying cause lost. | | | | | INTERVAL BETWEEN ONSET AND DEATH Sudden |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary sclerosis, left. Cardiac Hypertrophy. Pulmonary edema | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE Benedict Skitarelic | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | May 18, 1959 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF May 21, 1959 | | 22c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery | |
| | | | | 22d. LOCATION (City, town, or county) (State) Cumberland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight | | ADDRESS Cumberland, Md. | | 24a. REC'D BY REGISTRAR DATE MAY 20 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |



TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON QUALIFIED TO FURNISH THE INFORMATION REQUIRED. TO BE FILED IN THE OFFICE OF THE STATE HEALTH DEPARTMENT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5037

LAST NAME

FIRST NAME

MIDDLE NAME

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

Married ☐ Single ☐ Widowed ☐ Divorced ☐

Number of children ☐

Number of children living ☐

Number of children deceased ☐

Number of children in custody ☐

Number of children in institution ☐

Number of children in hospital ☐

Number of children in prison ☐

Number of children in other institution ☐

Number of children in other institution ☐

Number of children in other institution ☐

Number of children in other institution ☐

Number of children in other institution ☐

Number of children in other institution ☐

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Number of children in other institution ☐

Number of children in other institution ☐

CERTIFICATE OF DEATH

05045

Reg. Dist. No.

| | | | |
|---|------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | c. LENGTH OF STAY IN lb 30 DAYS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL AND WARWICK AVES. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle H Last REED | | 4. DATE OF DEATH Month MAY Day 2 Year 1959 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH DECEMBER 18 1891 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Train Master Railroad | | 10b. KIND OF BUSINESS OR INDUSTRY MARYLAND, Gilmore | 11. BIRTHPLACE (State or foreign country) U.S.A. |
| 13. FATHER'S NAME WILLIAM REED | | 14. MOTHER'S MAIDEN NAME JANE MULLAN | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 705-05-8054 | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH 3 weeks | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March 1957 to May 2 1959 , that I last saw the deceased alive on May 2 1959 , and that death occurred at 9:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 5/3/59 | | | |
| ACTUAL SIGNATURE DR. GEORGE SIMONS M.D. Cumberland Md | | | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 5-6-59 | 22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem. | 22d. LOCATION (City, town, or county) (State) Cumberland, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE James E. Scarpelli | | 24a. REC'D BY REGISTRAR DATE MAY 7 '59 | |
| ADDRESS Cumberland, Md. | | 24b. REGISTRAR'S SIGNATURE Arthur S. Hanes | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

07004

CERTIFICATE OF DEATH

3032

ALLIANCE

UNION

ALLIANCE

UNION

30 DAYS

UNION

IN A JANE KATHLEEN VILLAGE

EXHIBIT AND WARTON

1932

WY

REED

W

WY

1932

WY

1932

1932

1932

1932

1932

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1932

5039

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, | | c. LENGTH OF STAY IN 1b 27 MIN. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL & WARWICK AVE. MEMORIAL HOSPITAL | | d. STREET ADDRESS 310 BELLEVUE HGTS. | |
| 3. NAME OF DECEASED (Type or print) First BABY Middle BOY Last A RHODES | | 4. DATE OF DEATH Month MAY Day 11 Year 19 59 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAY 11, 1959 |
| 9. AGE (In years last birthday) NB yrs. | | 10. IF UNDER 1 YEAR Months 20 Days 20 Hours 20 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME MICHAEL E. RHODES | | 14. MOTHER'S MAIDEN NAME GRACE M. WHORTON | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Prematurity 24 wks (Twins) DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 4:06A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE Dr. W. B. Whitworth M.D. | | | |
| PHYSICIAN'S NAME (Type) DR. W. B. WHITWORTH | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | 22b. DATE THEREOF 5-12-59 | 22c. NAME OF CEMETERY OR CREMATORY Memorial Hospital | 22d. LOCATION (City, town, or county) (State) Cumberland, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | 24a. REC'D BY REGISTRAR DATE MAY 13 '59 | 24b. REGISTRAR'S SIGNATURE Arthur B. White |

2160275XV0

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

85048

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

CERTIFICATE OF DEATH

5030

ALLIANCE

ALLIANCE

CUMPRANCE

22 JUN

OF BIRTH

310 BELLEVUE HOSP

MEMORIAL HOSPITAL
1000 E. GERMER AVE.

11 MAY

2005

BABY BOY

WHITE

11 MAY 1955

U.S.A.

CHARLES W. WATSON

FRANK L. WATSON

MICHAEL E. WATSON

MEMORIAL HOSPITAL (CHICAGO), ILL.

DR. W. B. WATSON

5040

CERTIFICATE OF DEATH

Reg. Dist. No.

05047

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | c. LENGTH OF STAY IN 1b 13 HRS. 46 MIN. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL AND WARWICK AVENUES | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First BABY Middle BOY Last B RHODES | | 4. DATE OF DEATH Month MAY Day 11 Year 1959 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAY 11, 1959 |
| 9. AGE (In years last birthday) yrs. 13 | | 10. IF UNDER 1 YEAR Months 13 Days 46 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY CUMBERLAND MARYLAND | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME MICHAEL E. RHODES | | 14. MOTHER'S MAIDEN NAME GRACE M. WHORTON | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL CUMBERLAND, MD. | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 24 wks (twins) 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 5:27 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Fuller B. Whitworth M.D. PHYSICIAN'S NAME (Type) DR. F. B. WHITWORTH | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 22b. DATE THEREOF 5-12-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY Memorial Hospital | | 22d. LOCATION (City, town, or county) (State) Cumberland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS | | 24a. REC'D BY REGISTRAR DATE MAY 13 '59 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur L. Hines | |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

2260276X40

CERTIFICATE OF DEATH

5000

ILLUSTRATION

ILLUSTRATION

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5041 CERTIFICATE OF DEATH

05048

Reg. Dist. No.

| | | | |
|--|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 132 Humbird Street | | d. STREET ADDRESS 132 Humbert Street | |
| 3. NAME OF DECEASED (Type or print) NORA ALICE RIGGLEMAN | | 4. DATE OF DEATH May 3 19 59 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 31, 1876 |
| 9. AGE (In years last birthday) 82 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (State or foreign country) Oldtown, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Daniel Neus | | 14. MOTHER'S MAIDEN NAME Margaret Rannells | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Mrs. William Rice, Cumberland, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anemia 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma Stomach DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 3/23 1959 , to 5/3 1959 , that I last saw the deceased alive on 5/2 1959 , and that death occurred at 5:55 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 456 North Centre St. Cumberland, Md. DATE SIGNED 5/4/59 | | | |
| ACTUAL SIGNATURE Leo J. Ley, Jr. M.D. | | PHYSICIAN'S NAME (Type) Leo Ley M.D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF May 5, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY Mt. Herman Meth Cem. | | 22d. LOCATION (City, town, or county) (State) Allegany County, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland | | ADDRESS | |
| 24a. REC'D BY REGISTRAR MAY 6 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Hines | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1992-1993

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5072 CERTIFICATE OF DEATH

Reg. Dist. No. 05049

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Vale</u> | | c. LENGTH OF STAY IN 1b <u>1 year</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X La Vale</u> | | d. STREET ADDRESS <u>224 National Highway</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>224 National Highway</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>L.</u> Last <u>RUSMISEL</u> | | 4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>19 59</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 14, 1872</u> |
| 9. AGE (In years last birthday) <u>86</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u> | 11. BIRTHPLACE (State or foreign country) <u>Kansas</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>George Little</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Isabella Gill</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | |
| 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT Address <u>Mrs. F. T. Bell La Vale, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ravages of high Arteriosclerosis</u> DUE TO (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | | 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u> | |
| 21. I certify that I attended the deceased from <u>3/1/59</u> , 19 <u> </u> , to <u>5/3/59</u> , 19 <u> </u> , that I last saw the deceased alive on <u>5/3/59</u> , 19 <u> </u> , and that death occurred at <u>6:20</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cumberland, Md.</u> DATE SIGNED <u>5/5/59</u> ACTUAL SIGNATURE <u>Richard J. Williams</u> M.D. PHYSICIAN'S NAME (Type) <u>Richard J. Williams M.D.</u> <u>122 S. Centre St. Cumberland, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5/5/1959</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u> | | 22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Kight</u> | | ADDRESS <u>Cumberland, Md.</u> | |
| 24a. REC'D BY REGISTRAR DATE <u>MAY 6 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u> | |

CERTIFICATE OF DEATH

Reg. Dist. No.

05050

5042

| | | | |
|---|-------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | c. LENGTH OF STAY IN 1b 37 DAYS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL AND WARWICK AVENUES | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First ROBERT Middle L Last SHUMAKER | | 4. DATE OF DEATH Month MAY Day 26 Year 19 59 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH NOVEMBER 11, 1902 |
| 9. AGE (In years last birthday) 56 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carman | | 10b. KIND OF BUSINESS OR INDUSTRY W. M. R. R. | |
| 11. BIRTHPLACE (State or foreign country) FAIRHOPE, PENNSYLVANIA | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME JAMES F SHUMAKER | | 14. MOTHER'S MAIDEN NAME SARA R PERDEW | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyperplastic pleuritis (left) Generalized Peritonitis 519.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH 45 day | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial Degeneration | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 4/10/59 19, to 5/26/59 19, that I last saw the deceased alive on 5/26/59 , 19, and that death occurred at 3:55 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE R. J. Williams, M.D. | | ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED 5/26/59 | |
| PHYSICIAN'S NAME (Type) DR. R. J. WMS. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 5/29/59 | 22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cem. | 22d. LOCATION (City, town, or county) (State) Cumberland Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. | | 24a. REC'D BY REGISTRAR DATE JUN 1 '59 | |
| ADDRESS Cumb. Md | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

05050

CERTIFICATE OF DEATH

ALLIANCE

PARVILL

ALLIANCE

CLIFFORD

37

CLIFFORD

385 WALTON STREET

MEMORIAL AND MARRIAGE

1905

CHAMBER

ROBERT

NOVEMBER 11, 1905

WHITE

MALE

FAIRBANKS, MINN.

CARE & SERVICE

1905

CLIFFORD, MD.

MEMORIAL AND MARRIAGE

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(Faint, illegible text)

(Faint, illegible text)

(Faint, illegible text)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05051

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Allegany 5073 MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Jackson Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) FLORENCE SLOAN | | 4. DATE OF DEATH 5/6/1959 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/15/1875 |
| 9. AGE (In years last birthday) 83 yrs. | | IF UNDER 1 YEAR: Months 5 Days 6 IF UNDER 24 HRS. Hours 19 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY Pekin, MD. | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME James M. Sloan | | 14. MOTHER'S MAIDEN NAME Ella Frederick | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. NONE | |
| 17. INFORMANT Mr. D. Lindley Sloan, Cumberland, MD. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Charring Burns of Entire Body 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sudden DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Brother | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Burned to death in room. | |
| 20c. TIME OF INJURY Month, Day, Year May 6 1959 | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Per Home | 20f. (City or town) Lonaconing (County) Allegany (State) MD |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE W O McLane | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) W O McLane M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/8/1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY Memorial Park | | 22d. LOCATION (City, town, or county) Frostburg, MD. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHORN ADDRESS LONA CONING, MD. | | 24a. REC'D BY REGISTRAR MAY 11 '59 DATE | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05052

5043 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA VALE Cumberland | | c. LENGTH OF STAY IN Ib 16 DAYS | |
| d. NAME OF HOSPITAL (If not in hospital, address) MEMORIAL HOSPITAL WARWICK & MEMORIAL AVES. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Russell Middle THOMAS Last SMITH | | 4. DATE OF DEATH Month MAY Day 20 Year 1959 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH OCTOBER 30, 1880 |
| 9. AGE (In years for birthday) yrs. 78 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired custodian | | 10b. KIND OF BUSINESS OR INDUSTRY Allegany Co. School Board | |
| 11. BIRTHPLACE (State or foreign country) PENNSYLVANIA | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME MORGAN, SMITH | | 14. MOTHER'S MAIDEN NAME MARY Cavender | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 220-10-1944 | |
| 17. INFORMANT MEMORIAL HOSPITAL | | Address CUMBERLAND, MARYLAND | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Emphysema and Pneumonitis DUE TO (c) Arteriosclerotic & Hypertensive Heart Disease INTERVAL BETWEEN ONSET AND DEATH 3 weeks a) years b) 3 weeks Years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) a) Diverticulosis of Colon with hemorrhage; b) Old, Inactive Pulmonary | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Tuberculosis | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Tuberculosis | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 4th, 1959 to May 20th, 1959 , that I last saw the deceased alive on May 20th, 1959 , and that death occurred at 8:10 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Algonquin Hotel, Cumberland, Maryland. DATE SIGNED 5/21/59 | | | |
| ACTUAL SIGNATURE DR. DOERNER | | M.D. Algonquin Hotel, Cumberland, Maryland. | |
| PHYSICIAN'S NAME (Type) DR. DOERNER | | Cumberland, Maryland. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/23/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery | | 22d. LOCATION (City, town, or county) (State) Nr. Artemas, Penna. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George | | ADDRESS Cumberland, Md. | |
| 24a. REC'D BY REGISTRAR DATE MAY 25 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Hume | |

CERTIFICATE OF DEATH

1903

115002

NAME

AGE

16 DAYS

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5044 CERTIFICATE OF DEATH

Reg. Dist. No.

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|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | | | c. LENGTH OF STAY IN 1b 16 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM Henry SMITH | | | | 4. DATE OF DEATH Month Day Year MAY 28 1959 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 5/15, 1892 | |
| 9. AGE (In years last birthday) 67 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | | 11. IF UNDER 24 HRS. Months Days Hours Min. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carman | | | | 10b. KIND OF BUSINESS OR INDUSTRY B & O Railroad | | 11. BIRTHPLACE (State or foreign country) W. VA. Martinsburg | |
| 13. FATHER'S NAME JOHN H. SMITH | | | | 14. MOTHER'S MAIDEN NAME Mary S. Brant | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | | | 16. SOCIAL SECURITY NO. 705-05-5195 | | | |
| 17. INFORMANT PTS. OLD RECORD. | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) Chronic glomerulonephritis | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 wks. 3-4 yrs. 3 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Portal cirrhosis | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 21. I certify that I attended the deceased from July , 19 57 , to 5-28 , 19 59 , that I last saw the deceased alive on 5-28 , 19 59 , and that death occurred at 10:40 PM from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE William R. James | | | | ADDRESS (Street, city or town, state) 4411 Antioch St. Cumberland, Md. | | | |
| PHYSICIAN'S NAME (Type) W. JAMES, M.D. | | | | DATE SIGNED 5-30-59 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/31/59 | | 22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park | | 22d. LOCATION (City, town, or county) (State) Cumberland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, | | | | ADDRESS Cumberland, Maryland | | 24a. REC'D BY REGISTRAR DATE JUN 3 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Hines | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2000

CERTIFICATE OF DEATH

05054

Reg. Dist. No.

5064

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|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>Allegheny</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookings</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Savage</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners Hosp.</u> | | | | d. STREET ADDRESS <u>Church Hill</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Snelson</u> Last <u>Snelson</u> | | | | 4. DATE OF DEATH Month <u>5</u> Day <u>28</u> Year <u>1959</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>March 1, 1885</u> | |
| 9. AGE (In years last birthday) <u>71</u> yrs. | | IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min. <u>0</u> | | IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ins. Worker</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Kelly Springfield Ins.</u> | | 11. BIRTHPLACE (State or foreign country) <u>England</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>John Snelson</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Harriet Stenton</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown. WWI</u> | | | | 16. SOCIAL SECURITY NO. <u>215-10-1203</u> | | 17. INFORMANT Address <u>Mrs. Edith Spataro Rt. 2, Freiburg</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Lung infarct</u> DUE TO (c) <u>Arterio Sclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>11 days?</u> <u>11 days?</u> <u>10 days.</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>April 2</u> , 1959, to <u>May 28</u> , 1959, that I last saw the deceased alive on <u>May 28</u> , 1959, and that death occurred at <u>6:30 P. M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>W. E. Lattens</u> | | | | ADDRESS (Street, city or town, state) <u>167 E. Main St. Freiburg Md.</u> DATE SIGNED <u>5/29/59</u> | | | |
| PHYSICIAN'S NAME (Type) <u>W. E. Lattens</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>June 1, 1959</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>St. George Episcopal</u> | | 22d. LOCATION (City, town, or county) (State) <u>Mount Savage, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey L. Heigh</u> ADDRESS <u>Hyndman, Pa.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>JUN 2 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. No. 114

05054

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| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. DATE OF BIRTH | | 5. PLACE OF BIRTH | | 6. OCCUPATION | | 7. MARITAL STATUS | | 8. COLOR | | 9. RELIGION | | 10. EDUCATION | | 11. PLACE OF DEATH | | 12. DATE OF DEATH | | 13. TIME OF DEATH | | 14. CAUSE OF DEATH | | 15. MANNER OF DEATH | | 16. SIGNATURE OF PHYSICIAN | | 17. SIGNATURE OF REGISTRAR | | 18. SIGNATURE OF WITNESSES | | 19. SIGNATURE OF CORONER | | 20. SIGNATURE OF JURY | | 21. SIGNATURE OF JUDGE | | 22. SIGNATURE OF CLERK | | 23. SIGNATURE OF SHERIFF | | 24. SIGNATURE OF DEPUTY SHERIFF | | 25. SIGNATURE OF CONSTABLE | | 26. SIGNATURE OF JAILER | | 27. SIGNATURE OF PRISONER | | 28. SIGNATURE OF OTHER | | 29. SIGNATURE OF | | 30. SIGNATURE OF | | 31. SIGNATURE OF | | 32. SIGNATURE OF | | 33. SIGNATURE OF | | 34. SIGNATURE OF | | 35. SIGNATURE OF | | 36. SIGNATURE OF | | 37. SIGNATURE OF | | 38. SIGNATURE OF | | 39. SIGNATURE OF | | 40. SIGNATURE OF | | 41. SIGNATURE OF | | 42. SIGNATURE OF | | 43. SIGNATURE OF | | 44. SIGNATURE OF | | 45. SIGNATURE OF | | 46. SIGNATURE OF | | 47. SIGNATURE OF | | 48. SIGNATURE OF | | 49. SIGNATURE OF | | 50. SIGNATURE OF | | 51. SIGNATURE OF | | 52. SIGNATURE OF | | 53. SIGNATURE OF | | 54. SIGNATURE OF | | 55. SIGNATURE OF | | 56. SIGNATURE OF | | 57. SIGNATURE OF | | 58. SIGNATURE OF | | 59. SIGNATURE OF | | 60. SIGNATURE OF | | 61. SIGNATURE OF | | 62. SIGNATURE OF | | 63. SIGNATURE OF | | 64. SIGNATURE OF | | 65. SIGNATURE OF | | 66. SIGNATURE OF | | 67. SIGNATURE OF | | 68. SIGNATURE OF | | 69. SIGNATURE OF | | 70. SIGNATURE OF | | 71. SIGNATURE OF | | 72. SIGNATURE OF | | 73. SIGNATURE OF | | 74. SIGNATURE OF | | 75. SIGNATURE OF | | 76. SIGNATURE OF | | 77. SIGNATURE OF | | 78. SIGNATURE OF | | 79. SIGNATURE OF | | 80. SIGNATURE OF | | 81. SIGNATURE OF | | 82. SIGNATURE OF | | 83. SIGNATURE OF | | 84. SIGNATURE OF | | 85. SIGNATURE OF | | 86. SIGNATURE OF | | 87. SIGNATURE OF | | 88. SIGNATURE OF | | 89. SIGNATURE OF | | 90. SIGNATURE OF | | 91. SIGNATURE OF | | 92. SIGNATURE OF | | 93. SIGNATURE OF | | 94. SIGNATURE OF | | 95. SIGNATURE OF | | 96. SIGNATURE OF | | 97. SIGNATURE OF | | 98. SIGNATURE OF | | 99. SIGNATURE OF | | 100. SIGNATURE OF | |
|---------------------|--|--------|--|--------|--|------------------|--|-------------------|--|---------------|--|-------------------|--|----------|--|-------------|--|---------------|--|--------------------|--|-------------------|--|-------------------|--|--------------------|--|---------------------|--|----------------------------|--|----------------------------|--|----------------------------|--|--------------------------|--|-----------------------|--|------------------------|--|------------------------|--|--------------------------|--|---------------------------------|--|----------------------------|--|-------------------------|--|---------------------------|--|------------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|------------------|--|-------------------|--|

CERTIFICATE OF DEATH

Reg. Dist. No.

05055

5065

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| 1. PLACE OF DEATH a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg | | | | c. LENGTH OF STAY IN 1b 10 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First MARY Middle ETTA Last STARK | | | | 4. DATE OF DEATH Month May Day 3 Year 19 59 | | | |
| 5. SEX F | | 6. COLOR OR RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH June 29, 1886 | |
| 9. AGE (In years last birthday) 72 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Maryland, Garrett Co. U.S. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | | | | |
| 13. FATHER'S NAME Archibald | | | | 14. MOTHER'S MAIDEN NAME Helena Otto | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No | | | | 16. SOCIAL SECURITY NO. 214-32-3459 | | | |
| 17. INFORMANT Mr. Orville Stark Husband | | | | Address Lonaconing, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure INTERVAL BETWEEN ONSET AND DEATH 2 weeks 491x DUE TO Bronchopneumonia 1 month Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis Cerebral thrombosis | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 4/1 , 19 59 , to 5/2 , 19 59 , that I last saw the deceased alive on 5/2 , 19 59 , and that death occurred at 10:45 M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Mikio Kato M.D. | | | | ADDRESS (Street, city or town, state) 51 Main St. Lonaconing, Md. | | | |
| DATE SIGNED 5/3/59 | | | | | | | |
| PHYSICIAN'S NAME (Type) MIKIO KATO | | | | Lonaconing, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/6/59 | | 22c. NAME OF CEMETERY OR CREMATORY United Church of Christ New Germany, Garrett Co., Md. | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Don Newman | | | | ADDRESS Greentville, Md. | | 24a. REC'D BY REGISTRAR DATE MAY 7 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur L. Thomas | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 15

1995-1996

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1. The first part of the document is a list of names and titles, including "The Hon. Mr. Justice" and "The Hon. Mr. Justice".

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• 64, indicated.

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5066 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH o. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg | | c. LENGTH OF STAY IN 1b 1 Week | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 37 Linden Street | | | | d. STREET ADDRESS 34 McCulloh Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Grace Middle I. Last Stevens | | | | 4. DATE OF DEATH Month May Day 6th Year 1959 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH January 3rd, 1896 | | 9. AGE (In years last birthday) 63 yrs. | IF UNDER 1 YEAR Months 63 Days 63 Hours 63 Min. | IF UNDER 24 HRS. Months 63 Days 63 Hours 63 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dish Washer | | 10b. KIND OF BUSINESS OR INDUSTRY Restaurant | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John Short | | | | 14. MOTHER'S MAIDEN NAME Nancy Lourie | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. 215-14-6369 | | INFORMANT Address Clarence Stevens, 34 McCulloh St. F'bg. Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease DUE TO (b) years - Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July , 19 1958 to may 6 , 19 59 , that I last saw the deceased alive on may 6 , 19 59 , and that death occurred at 11:AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2 Broadway DATE SIGNED 5/8/59 | | | | | | | |
| ACTUAL SIGNATURE John B. Davis | | PHYSICIAN'S NAME (Type) John B. Davis, Md. Frostburg, Md. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5-9-59 | | 22c. NAME OF CEMETERY OR CREMATORY Eckhart Cemetery | | 22d. LOCATION (City, town, or county) (State) Eckhart, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md. | | | | 24a. REC'D BY REGISTRAR DATE MAY 11 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Hines | |

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Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

05038

WESTLAND STATE DEPARTMENT OF HEALTH - BATHING 12



CERTIFICATE OF DEATH

05038

Albany

Albany

Albany

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CERTIFICATE OF DEATH

Reg. Dist. No.

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|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | c. LENGTH OF STAY IN lb 1 DAY | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL AND WARWICK AVENUES | | e. STREET ADDRESS 102 EAST OLDTOWN RD. | |
| 3. NAME OF DECEASED (Type or print) First ROBERT Middle Last THWAITES St | | 4. DATE OF DEATH Month MAY Day 18 Year 1959 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH AUGUST 7, 1873 |
| 9. AGE (In years last birthday) yrs. 85 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired inspector | | 10b. KIND OF BUSINESS OR INDUSTRY Underwriters Insp. | |
| 11. BIRTHPLACE (State or foreign country) PENNSYLVANIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME HARRY THWAITES | | 14. MOTHER'S MAIDEN NAME Sara Becker | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT MEMORIAL HOSPITAL | | Address CUMBERLAND, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arteriosclerosis (c) 5 yrs | | | INTERVAL BETWEEN ONSET AND DEATH 5 yrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from May 10, 1959 , to May 18, 1959 , that I last saw the deceased alive on May 18, 1959 , and that death occurred at 8:10 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Clay E. Durrett | | ADDRESS (Street, city or town, state) 236 W. 4th Cumberland | |
| PHYSICIAN'S NAME (Type) DR. CLAY E. DURRETT | | DATE SIGNED 5/18/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 5/22/59 | 22c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery | 22d. LOCATION (City, town, or county) (State) Norristown Pa |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox | | ADDRESS Cumberland Maryland | |
| 24a. REC'D BY REGISTRAR MAY 22 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

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DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1913

REGISTERED

MARY J. M.

WHITE

WHITE

OF BERKLEY

1 DAY

CLAYTON

100 EAST OGDEN ST.

CLAYTON HOSPITAL

THIRTY

THIRTY

AUGUST 7, 1913

WHITE

U.S.A.

BERKLEY

WHITE

CLAYTON HOSPITAL

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WHITE

CLAYTON HOSPITAL

CLAYTON HOSPITAL

CLAYTON HOSPITAL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 05058

5046

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|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 5 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVENUES | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND, d. STREET ADDRESS 1 322 RESERVOIR AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First HENRY Middle VALENTINE Last VALENTINE | | 4. DATE OF DEATH Month MAY Day 8 Year 1959 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JULY 24, 1884 |
| 9. AGE (In years last birthday) 74 yrs. | | 10. IF UNDER 1 YEAR Months 74 Days 74 Hours 74 Min. 74 | 11. IF UNDER 24 HRS. Months 74 Days 74 Hours 74 Min. 74 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY W. Md. R.R. | 11. BIRTHPLACE (State or foreign country) MARYLAND Cumberland |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME WILLIAM VALENTINE | |
| 14. MOTHER'S MAIDEN NAME Mary ELIZABETH LUTMAN | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. 705-10-7913 | | 17. ADDRESS MEMORIAL HOSPITAL CUMBERLAND MD. | |
| 18. CAUSE OF DEATH [Enter only one cause prevailing for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Uremia + Coma 792x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 792x DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Thrombosis Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH 3 days | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 5/2/59 , 19, to 5/8/59 , 19, that I last saw the deceased alive on 5/2/59 , 19, and that death occurred at 3:35 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Dr. R. J. Wms. ADDRESS (Street, city or town, state) Cumberland Md 5/9/59 DATE SIGNED 5/9/59 | | | |
| PHYSICIAN'S NAME (Type) DR. R. J. WMS. 122 So. Centre Street, Cumberland, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF May 11, 1959 | 22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park | 22d. LOCATION (City, town, or county) (State) Cumberland, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland | | 24a. REC'D BY REGISTRAR DATE MAY 13 '59 | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

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VS A15 (4)
15M 9/58

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THE CASE OF DRAIN

5046

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WESTMORLAND

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SEE RECORD IN FILE

IN FILE 1 & 2

VALLEY

EMRY

JULY 24, 1881

WHITE

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W. H. H. H.

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WYLLIS, CONSTRUCTION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5047 CERTIFICATE OF DEATH

05059

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | c. LENGTH OF STAY IN 1b 2/14/59 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Bessie Brown Walker | | 4. DATE OF DEATH Month May Day 1 Year 1959 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8/20/1871 |
| 9. AGE (In years last birthday) 87 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME John Brown | | 14. MOTHER'S MAIDEN NAME Mary Hutchins | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT P.O. Box 599 | | Address Cumberland, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial Degeneration 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) Senile Deterioration | | INTERVAL BETWEEN ONSET AND DEATH ? ? ? | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome - Psychotic reaction | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 2/14/59 , 19____, to 5/1/59 , 19____, that I last saw the deceased alive on 4/30/59 , 19____, and that death occurred at 4:20 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE James E. McLean | | ADDRESS (Street, city or town, state) 49 Greene St. | |
| PHYSICIAN'S NAME (Type) Dr. James E. McLean | | DATE SIGNED 5/1/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF May 3, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cem. | | 22d. LOCATION (City, town, or county) (State) Moscow, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight | | ADDRESS Cumberland, Md. | |
| 24a. REC'D BY REGISTRAR MAY 4 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

210

CERTIFICATE OF DEATH

Reg. Dist. No.

5048

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE WEST VIRGINIA b. COUNTY MINERAL | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | c. LENGTH OF STAY IN 1b 9 DAYS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL AND WARWICK HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First WILLIAM Middle FRANK Last WEAKLEY | | 4. DATE OF DEATH Month MAY Day 8 Year 19 59 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAY 9, 1894 |
| 9. AGE (In years lost birthday) 64 yrs. | | 10. IF UNDER 1 YEAR Months 64 Days 64 Hours 64 Min. | 11. IF UNDER 24 HRS. Months 64 Days 64 Hours 64 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bus Driver | | 10b. KIND OF BUSINESS OR INDUSTRY Transportation | |
| 11. BIRTHPLACE (State or foreign country) VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME EMMETT WEAKLEY | | 14. MOTHER'S MAIDEN NAME ARDENA LAMB | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X 331X DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Cerebral Vascular Accident DUE TO (c) Cerebral Vascular Accident PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331X INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 4/29 , 19 59 , to 5/8 , 19 59 , that I last saw the deceased alive on 5/8 , 19 59 , and that death occurred at 3:45 P.M. from the causes and on the date stated above. DATE SIGNED 5/9/59 ACTUAL SIGNATURE Leo H. Ley, Jr. M.D. 450 N. Centre St. PHYSICIAN'S NAME (Type) DR. LEO H. LEY Cumberland Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5-11-1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Cem. | | 22d. LOCATION (City, town, or county) (State) Cumberland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George | | 24a. REC'D BY REGISTRAR DATE MAY 12 '59 | |
| ADDRESS Cumberland, Md. | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kline | |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

05000

STATE OF TEXAS
COUNTY OF DALLAS

INVESTIGATION

INVESTIGATION

INVESTIGATION

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1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5049 CERTIFICATE OF DEATH

05061

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH o. COUNTY <u>Allegany</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> | | | | c. LENGTH OF STAY IN lb <u>65 Years</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>833 Windsor Road</u> | | | | d. STREET ADDRESS <u>833 Windsor Road</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Augustus</u> Last <u>Williams</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>10</u> Year <u>19 59</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>March 9, 1894</u> | |
| 9. AGE (In years last birthday) <u>65</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Alleg Inst. Company</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>James Bradley Williams</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Adele Knipper</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | | | | 16. SOCIAL SECURITY NO. <u>W.W.I 216-22-5188</u> | | | |
| 17. INFORMANT <u>Mrs. Frances Williams</u> | | | | Address <u>Cumberland, Maryland</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>Myocardial Fibrosis</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>14 yrs.</u> <u>14 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | |
| 20f. (City or town) <u> </u> | | | | 20g. (County) <u> </u> | | 20h. (State) <u> </u> | |
| 21. I certify that I attended the deceased from <u>Sept. 17, 1949</u> , to <u>May 10, 1959</u> , that I last saw the deceased alive on <u>April 29, 1959</u> , and that death occurred at <u>4 A. M.</u> from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) <u>50 Pershing Street</u> | | | | DATE SIGNED <u> </u> | | | |
| ACTUAL SIGNATURE <u>Samuel M. Jacobson</u> M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>Samuel M. Jacobson, M. D.</u> | | | | <u>Cumberland, Maryland</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5/13/59</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Ruth E. Silcox</u> | | | | ADDRESS <u>Cumberland, Maryland</u> | | 24a. REC'D BY REGISTRAR <u>MAY 15 '59</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15001

CERTIFICATE OF DEATH

1908

| | | | |
|--|--|--|--|
| <p>1. Name of deceased: <u>John Doe</u></p> | | <p>2. Sex: <u>Male</u></p> | |
| <p>3. Age: <u>45</u></p> | | <p>4. Date of birth: <u>Jan 1, 1863</u></p> | |
| <p>5. Place of birth: <u>Maryland</u></p> | | <p>6. Date of death: <u>Dec 15, 1908</u></p> | |
| <p>7. Cause of death: <u>Coronary thrombosis</u></p> | | <p>8. Place of death: <u>Home</u></p> | |
| <p>9. Signature of physician: <u>John Doe</u></p> | | <p>10. Signature of registrar: <u>John Doe</u></p> | |
| <p>11. Date of registration: <u>Dec 16, 1908</u></p> | | <p>12. Place of registration: <u>Baltimore</u></p> | |
| <p>13. Name of informant: <u>John Doe</u></p> | | <p>14. Address of informant: <u>123 Main St</u></p> | |
| <p>15. Name of informant: <u>John Doe</u></p> | | <p>16. Address of informant: <u>123 Main St</u></p> | |
| <p>17. Name of informant: <u>John Doe</u></p> | | <p>18. Address of informant: <u>123 Main St</u></p> | |
| <p>19. Name of informant: <u>John Doe</u></p> | | <p>20. Address of informant: <u>123 Main St</u></p> | |
| <p>21. Name of informant: <u>John Doe</u></p> | | <p>22. Address of informant: <u>123 Main St</u></p> | |
| <p>23. Name of informant: <u>John Doe</u></p> | | <p>24. Address of informant: <u>123 Main St</u></p> | |
| <p>25. Name of informant: <u>John Doe</u></p> | | <p>26. Address of informant: <u>123 Main St</u></p> | |
| <p>27. Name of informant: <u>John Doe</u></p> | | <p>28. Address of informant: <u>123 Main St</u></p> | |
| <p>29. Name of informant: <u>John Doe</u></p> | | <p>30. Address of informant: <u>123 Main St</u></p> | |
| <p>31. Name of informant: <u>John Doe</u></p> | | <p>32. Address of informant: <u>123 Main St</u></p> | |
| <p>33. Name of informant: <u>John Doe</u></p> | | <p>34. Address of informant: <u>123 Main St</u></p> | |
| <p>35. Name of informant: <u>John Doe</u></p> | | <p>36. Address of informant: <u>123 Main St</u></p> | |
| <p>37. Name of informant: <u>John Doe</u></p> | | <p>38. Address of informant: <u>123 Main St</u></p> | |
| <p>39. Name of informant: <u>John Doe</u></p> | | <p>40. Address of informant: <u>123 Main St</u></p> | |
| <p>41. Name of informant: <u>John Doe</u></p> | | <p>42. Address of informant: <u>123 Main St</u></p> | |
| <p>43. Name of informant: <u>John Doe</u></p> | | <p>44. Address of informant: <u>123 Main St</u></p> | |
| <p>45. Name of informant: <u>John Doe</u></p> | | <p>46. Address of informant: <u>123 Main St</u></p> | |
| <p>47. Name of informant: <u>John Doe</u></p> | | <p>48. Address of informant: <u>123 Main St</u></p> | |
| <p>49. Name of informant: <u>John Doe</u></p> | | <p>50. Address of informant: <u>123 Main St</u></p> | |
| <p>51. Name of informant: <u>John Doe</u></p> | | <p>52. Address of informant: <u>123 Main St</u></p> | |
| <p>53. Name of informant: <u>John Doe</u></p> | | <p>54. Address of informant: <u>123 Main St</u></p> | |
| <p>55. Name of informant: <u>John Doe</u></p> | | <p>56. Address of informant: <u>123 Main St</u></p> | |
| <p>57. Name of informant: <u>John Doe</u></p> | | <p>58. Address of informant: <u>123 Main St</u></p> | |
| <p>59. Name of informant: <u>John Doe</u></p> | | <p>60. Address of informant: <u>123 Main St</u></p> | |
| <p>61. Name of informant: <u>John Doe</u></p> | | <p>62. Address of informant: <u>123 Main St</u></p> | |
| <p>63. Name of informant: <u>John Doe</u></p> | | <p>64. Address of informant: <u>123 Main St</u></p> | |
| <p>65. Name of informant: <u>John Doe</u></p> | | <p>66. Address of informant: <u>123 Main St</u></p> | |
| <p>67. Name of informant: <u>John Doe</u></p> | | <p>68. Address of informant: <u>123 Main St</u></p> | |
| <p>69. Name of informant: <u>John Doe</u></p> | | <p>70. Address of informant: <u>123 Main St</u></p> | |
| <p>71. Name of informant: <u>John Doe</u></p> | | <p>72. Address of informant: <u>123 Main St</u></p> | |
| <p>73. Name of informant: <u>John Doe</u></p> | | <p>74. Address of informant: <u>123 Main St</u></p> | |
| <p>75. Name of informant: <u>John Doe</u></p> | | <p>76. Address of informant: <u>123 Main St</u></p> | |
| <p>77. Name of informant: <u>John Doe</u></p> | | <p>78. Address of informant: <u>123 Main St</u></p> | |
| <p>79. Name of informant: <u>John Doe</u></p> | | <p>80. Address of informant: <u>123 Main St</u></p> | |
| <p>81. Name of informant: <u>John Doe</u></p> | | <p>82. Address of informant: <u>123 Main St</u></p> | |
| <p>83. Name of informant: <u>John Doe</u></p> | | <p>84. Address of informant: <u>123 Main St</u></p> | |
| <p>85. Name of informant: <u>John Doe</u></p> | | <p>86. Address of informant: <u>123 Main St</u></p> | |
| <p>87. Name of informant: <u>John Doe</u></p> | | <p>88. Address of informant: <u>123 Main St</u></p> | |
| <p>89. Name of informant: <u>John Doe</u></p> | | <p>90. Address of informant: <u>123 Main St</u></p> | |
| <p>91. Name of informant: <u>John Doe</u></p> | | <p>92. Address of informant: <u>123 Main St</u></p> | |
| <p>93. Name of informant: <u>John Doe</u></p> | | <p>94. Address of informant: <u>123 Main St</u></p> | |
| <p>95. Name of informant: <u>John Doe</u></p> | | <p>96. Address of informant: <u>123 Main St</u></p> | |
| <p>97. Name of informant: <u>John Doe</u></p> | | <p>98. Address of informant: <u>123 Main St</u></p> | |
| <p>99. Name of informant: <u>John Doe</u></p> | | <p>100. Address of informant: <u>123 Main St</u></p> | |

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE REGISTRAR OF DEATHS, COUNTY OF BALTIMORE, MARYLAND.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05062

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY ALLEGANY 5050 MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY Mineral | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PIEDMONT 85x-3 | |
| c. LENGTH OF STAY IN 1b 13 HRS | | d. STREET ADDRESS BOX 165 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL & WARWICK AVES., MEMORIAL HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last GENEVIEVE JANE WISHON | | 4. DATE OF DEATH Month Day Year MAY 27 1959 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAY 21, 1956 |
| 9. AGE (In years last birthday) 3 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) KEYSER, W.VA. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME CLYDE WISHON | | 14. MOTHER'S MAIDEN NAME EDITH KADY | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMATION MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial Hemorrhage, Maceration of Brain. 802X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Skull fracture DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 13 Hrs. 13 Hrs. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck By Train (Railroad) | |
| 20c. TIME OF INJURY Month, Day, Year 7:30 p.m. May 26 1959 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Railroad track | 20f. (City or town) (County) (State) Near Piedmont, Mineral, W.Va. |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Benedict Skitarelic M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/30/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY Westernport, Md. | | 22d. LOCATION (City, town, or county) (State) Westernport Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE E. J. Boul | | 24a. REC'D BY REGISTRAR DATE JUN 1 '59 | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus |

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